St George's University Hospitals NHS
NHS Foundation Trust

Quality Account
2016/17

Excellence in specialist and community healthcare

Contents

Quality Report

Chief Executive's statement on quality

Providing high quality care to our patients is our number one priority, and we need to ensure we put quality – and the safety of our patients – at the forefront of everything we do.

The Care Quality Commission's inspection report for St George's, published in November following their visit in June 2016, raised concerns about the quality of care the Trust provides in certain areas, and we were placed in special measures for quality as a result. We are developing a Quality Improvement Plan to help us address the issues identified by the CQC. But our plan needs to be about much more than this – we need all 9,000 of our staff, wherever they work, to want to make St George's better for patients, and the communities we serve.

This means engaging staff in the quality improvement process – which involves listening to their concerns, and taking time to truly understand where they feel improvements need to be made. This is a key priority for us over the coming months, and crucial to us achieving the step-change in quality we all believe the organisation needs.

Last year, the Trust set out a range of quality ambitions under the headings of Patient Safety, Patient Experience and Patient Outcomes. As you will read in the report that follows, we have made significant progress in some areas. For example, our Standard Hospital Mortality Rate (SHMR) - which measures whether our mortality rate is higher or lower than expected for a Trust of our size - is currently 81%, showing an improvement from 85% in 2015. We are also prioritising our care for patients with dementia and delirium, and in the past year have established a new and improved delirium pathway.

In all areas, there is still a huge amount to do; for example we still need to deliver much needed improvements to the way in which we handle and manage complaints. Whilst every complaint is one too many, we need to maximise our learning from them so as to help us prevent a recurrence in the future.

Quality priorities for 2017/18

For the coming year, we have set new ambitions, whilst also making sure we build on the work already started. These priorities have been agreed with our stakeholders and governors, who play a crucial role in helping to shape our quality ambitions for the organisation.

Our priorities include:

- Improved levels of Early Warning Score documentation
- Staff survey response increase to 60%
- Reduction of on the day theatre cancellations by 25%
- Ensuring that all patients and their relatives have fully documented discussions and agreed plans for End of Life care.

Given our financial and performance challenges, it is my job, and that of the senior team, to ensure we retain our focus on quality, as that is what our patients rightly expect us to do.

Jacqueline Totterdell

Chief Executive
31 May 2017

Review of Services

St George's is the largest healthcare provider in south west London, and one of the largest in the country. St George's serves a population of 1.3 million people across south west London. A large number of services, like cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

Most of the services are provided at St George's Hospital in Tooting, but we also provide many services from Queen Mary's Hospital in Roehampton, health centres across Wandsworth, Wandsworth Prison and from GP surgeries, schools, nurseries and in patients' own homes.

We also provide care for patients from a larger catchment area in south east England for specialist services like complex pelvic trauma. Some of our services also treat patients from all over the country, including for family HIV care, bone marrow transplantation for non-cancer diseases and penile cancer.

A number of our services are members of established clinical networks which bring together doctors, nurses and other clinicians from a range of healthcare providers working to improve clinical outcomes and patient experience. These networks include the South London Cardiac and Stroke Network and the South West London and Surrey Trauma Network, for which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

During 2016/17 we provided and/or subcontracted 54 NHS services. We have reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of NHS services by St George's University Hospitals NHS Foundation Trust for 2016/17.

Further information about the services we provide and where they are based is outlined in Appendix F.

Statement from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It regulates care provided by the NHS, local authorities, private companies and voluntary organisations that provide regulated activities under the Health and Social Care Act 2008.

The CQC registers, and therefore licenses, all NHS Trusts. It monitors Trusts to make sure they continue to meet very high standards of quality and safety. If services drop below the CQC's fundamental standards it can require action to be taken, impose fines, issue public warnings, or launch investigations. In extreme cases it has the power to close services down.

The CQC inspection framework focuses on five domains:

- Are services **safe**? Are people protected from abuse and avoidable harm?
- Are services **effective**? Does people's care and treatment achieve good outcomes and promote a good quality of life, and is it evidence based where possible?
- Are services **caring**? Do staff involve and treat people with compassion, kindness, dignity and respect?
- Are services **responsive**? Are services organised so that they meet people's needs?
- Are services **well led**? Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?

The CQC rating system has four categories - **outstanding, good, requires improvement or inadequate**. NHS Trusts are given an overall rating and a range of services within the Trust are also given one of these four ratings.

St George's University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status overall is 'Inadequate' for quality. St George's has no conditions placed upon its CQC registration.

The Care Quality Commission has also taken enforcement action against St George's during 2016/17, under Section 29A.

St George's University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC Inspection in 2016

The Trust was rated as **good** overall in a 2014 CQC comprehensive inspection. A further comprehensive inspection in June 2016 rated the Trust as **inadequate**. This most recent inadequate rating reflects a marked deterioration in the safety and quality of some of the Trust services, as well as to its overall governance and leadership.

Whilst the CQC have rated the Trust as inadequate overall, they noted good care in several areas and some outstanding practice, including in maternity. The Trust was rated as **good** overall under the CQC 'Caring' domain.

It is important to note that at the time of the inspection, the Trust had introduced a range of supportive and recovery mechanisms as a means of stabilising the organisation. An interim Chair and Chief Executive had been appointed to offer the organisation direction and to develop a robust and deliverable recovery plan. A number of interim appointments had been made to ensure there was focused leadership in place to implement the organisation's recovery plan.

The executive team was clear about the challenges that they and the Trust faced and acknowledged the need for significant improvement across the organisation. Key substantive appointments were made to the non-executive board, which included the appointment of individuals with significant experience and expertise in regards to improving patient safety.

Other contributing factors for the deterioration in the Trust's overall CQC rating include; *neglect of maintenance of its buildings, failure to ensure the requirements of the fit and proper persons regulation had been implemented, and a leadership culture which was weighted towards trying to achieve financial stability, which inadvertently impacted on the quality of services being provided.*

Members of the executive and non-executive recognised that an attitude of 'learnt helplessness' existed across the organisation. Both the Chairman and Chief Executive recognised the need to improve staff engagement, to develop a long term sustainable vision and strategy for the organisation, and to reintroduce accountability and strong leadership across all divisions within the Trust.

Section 29A Warning Notice

Following their June inspection, the CQC issued a letter of intent to the Trust proposing to take urgent enforcement action under Section 31 of the Health and Social Care Act, 2008 due to the state of disrepair of some buildings at St George's Hospital. In response to this action by the CQC, the Trust took appropriate improvement measures which resulted in the CQC enforcement notice being withdrawn.

However, the CQC issued a Section 29A Warning Notice to the Trust in August 2016 for breaches in regulations that required significant improvement regarding *premises and equipment, mental capacity assessments and best interest decisions, good governance* and the *fit and proper persons requirement.*

Under the 29A Warning Notice, the CQC determined that within the Trust:

1. There were unsafe and unfit premises where healthcare is provided and accommodates staff
2. There was a lack of formal mental capacity assessments and best interest decision making and that some patients had decisions made for them that they were capable of making themselves
3. The design and operation of the governance arrangements were not effective in identifying and mitigating significant risks to patients
4. Risks to the delivery of high quality care were not being systematically identified, analysed and mitigated
5. Staff were not being held to account for the management of specific risks
6. There were a lack of processes in place to provide systematic assurance that high quality care is being delivered; priorities for assurance had not been agreed and were not kept under review. Effective action had not been taken when risks were not mitigated
7. The data used in reporting, performance management and delivering high quality care was not robust and valid
8. There were not suitable arrangements in place for ensuring that directors are fit and proper

The Trust implemented an immediate action plan in response to the Section 29A warning and wrote to the CQC in November 2016, confirming that actions relating to the issues identified had either been completed or were being addressed.

The CQC inspected the Trust in relation to the Section 29A progress on 10, 11 and 22 May 2017. The Trust will receive the CQC's outcome report from these inspections in late June 2017.

Overall CQC inspection rating

The CQC rated 60 specific standards across the Trust during their inspection in June 2016. Out of these:

- 1 was rated as outstanding
- 27 were rated as good
- 23 were rated as requires improvement
- 8 were rated as inadequate

The full breakdown of how our hospitals performed against each of the five CQC essential domains is set out in the following tables.

CQC ratings for St George's Hospital - Tooting

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Urgent and emergency services	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Medical Care	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Outstanding	Good	Good	Good	Good
Services for children & Young People	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
End of Life care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Outpatients and diagnostic imaging	Requires Improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

CQC ratings for Community Services

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Community health services for adults	Good	Good	Good	Good	Requires Improvement	Good
Community health services for children, young people and families	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community health inpatient services	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Community End of Life Care services	Requires Improvement	Inadequate	Good	Requires Improvement	Inadequate	Inadequate
Overall Community	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement

CQC ratings for St George's University Hospitals NHS Foundation Trust

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

The CQC reported its findings back to us at a quality summit that included representatives from:

- St George's University Hospitals NHS Foundation Trust
- The CQC
- NHS Improvement
- NHS England
- Wandsworth Council
- Healthwatch Wandsworth
- Wandsworth CCG
- Merton CCG

In its report on the Trust the CQC highlighted several areas of outstanding practice:

- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were amongst the best in the country
- The outcomes achieved by the specialist medical and surgical services provided by the hospital
- The effectiveness of maternity care delivered by the hospital
- The responsiveness of the neonatal unit to parents whilst their baby was on the unit, and the support provided by the outreach nurse
- The involvement of children of varying ages on the interview panel as part of the recruitment process for ED paediatric nurses

The CQC reported that the Trust must take actions to:

- Develop a long term strategy and vision
- Move towards having a stable, substantive leadership team
- Ensure all premises and facilities are safe, well maintained and fit for purpose
- Ensure all care is delivered in accordance with the Mental Capacity Act, 2005, when appropriate
- Review and implement robust governance processes, so that patients receive safe and effective care. Ensure 18 week Referral to Treatment (RTT) data is robust and accurate so that patients are given appointments and treatment based on their needs and within national targets
- Ensure serial numbers of prescriptions (FP10s) for prescribers are always monitored for use
- Ensure radiographers only administer medication (contrast media) where appropriately authorised
- Patient Group Directions (PGDs) are in place
- Ensure the fit and proper persons' requirement regulations for directors are always complied with
- Ensure the paediatric ward environment, staffing and training requirements are suitable for treating and caring for children and young people with mental health conditions
- Ensure medicines are stored in an appropriate manner, by keeping cupboards locked when not in use
- Ensure the process for decontamination of nasoendoscopes is compliant with guidance

The CQC also reported that the Trust should:

- Maintain patient privacy, dignity and confidentiality at all times

- Review the fluid storage within the ED major incident cupboard to ensure that training equipment is not stored with 'live' equipment
- Ensure that staff consistently follow guidance related to the prevention of healthcare associated infections with specific regard to hand hygiene
- Ensure medical equipment across the Trust stored on is cleaned and that there are systems in place for monitoring the cleanliness of equipment returned to the ward
- Ensure all staff caring for children receive level 3 safeguarding training
- Ensure the process for investigating serious incidents is timely and undertaken by people trained in investigation so they understand the root causes of an incident and identify measurable action
- Minimise the cancellation of operations and when this cannot be avoided, they are rescheduled within 28 days
- Reduce the moves of patients to wards that are not appropriate
- Ensure that staff use the early warning scoring system effectively, including the timely escalation of deteriorating patients to relevant personnel
- Ensure divisional and Trust priorities are shared by personnel of all grades and professions who work together to promote the quality and safety of patient care
- Address the low morale among theatre staff and consultant surgeons
- Replace damaged chairs and furniture within patient areas so that they can be thoroughly cleaned
- Ensure that all patients within the ED 'streaming' area are assessed within a private area
- Ensure staff can observe the patients whilst they are waiting in their outpatient departments
- Ensure patient electronic records are not easily visible or their paper records are not easily accessible by the public
- Improve the percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets
- Communicate effectively with patients when outpatient clinics overrun
- Ensure there are sufficient cystoscopes (to examine the inside of the bladder) to supply day surgery, main theatres and endoscopy
- Ensure all relevant staff are appropriately inducted to the Trust and within clinical environments to which they are allocated to work

Trust Quality Improvement Plan 2017/18

Following the inspection by the CQC the Trust prepared a detailed Quality Improvement Plan (QIP). The plan takes account of pre-existing compliance matters, the Section 29A warning notice from the CQC and all the 'must do' and 'should do' recommendations from the CQC reports which formed the basis for their judgement and rating for the Trust in June 2016.

The Trust's long term aim is to achieve a 'good' or 'outstanding' rating from the CQC by 2019.

The three phases of the QIP:

Phase 1 is expected to conclude on or before 30 September 2017, and essentially addresses the immediate compliance concerns highlighted by CQC. The focus for Phase 1 of the QIP is mandated in accordance with NHS Improvement's (NHSI's) enforcement undertakings. Successful implementation of Phase 1 will lead to the withdrawal, by the CQC, of the Section 29A Warning Notice and, following satisfactory conclusion of NHSI's enforcement undertakings, lead to a recommendation for the Trust to exit special measures for quality.

Phase 2 is primarily concerned with embedding good governance and compliance across Trust acute and community services and is designed to allow the progression from an 'inadequate' rating to a 'requires improvement' rating by quarter 4 of 2018/19. Elements of Phase 2 may require further evolution and refinement following completion of an independent well-led governance review required as part of NHSI's enforcement undertakings.

Phase 3 is primarily concerned with building capability, confidence and competence, allowing the progression from a 'requires improvement' rating to the restoration of an overall Trust rating of at least 'good' by the end of 2019.

The CQC will undertake a full inspection at the Trust as part of their continued announced inspection regime, planned for the financial year 2017/18.

Priorities for improvement and statements of assurance from the board

Developing the quality account

All NHS Trusts report the same information, which allows us to benchmark our performance against other Trusts. This is important for not only letting us know how we are doing in terms of performance, but also means that we can learn from other Trusts who offer similar services.

The Department of Health (DH) and NHS Improvement produce guidance on what should be reported in the quality account for NHS Trusts and NHS foundation Trusts (from 1st April 2016 Monitor and the Trust Development Authority merged and were renamed NHS Improvement).

We must comply with NHS Improvement's reporting requirements and additionally those set by the Department of Health. NHS Improvement requires us to produce an annual quality report which includes all of the reporting requirements of the quality account, plus some additional requirements that they have set.

To meet both DH and NHS Improvement's quality reporting requirements, we have consolidated all Trust quality information into one document – known as the 'quality report'. However, for reporting purposes to DH we will call the quality report the 'quality account'.

Priorities for improvement in 2017/18

We have agreed commitments against each of the patient domains outlined below. These priorities have been determined through a review of activity during 2016/17 and via feedback from our stakeholders.

The priorities indicated are reflected in the Trust Quality Improvement Plan for 2017/18 and each element has agreed outcomes with a nominated person accountable for delivery against the priorities.

Improving patient safety

- Improved levels of Early Warning Score documentation
- Rollout of Local Safety Standards for Invasive Procedures (LOCSSIPS)
- A 25% reduction in patient falls resulting in fractures
- No avoidable Grade 4 pressure ulcers in patients
- No avoidable in-patient cardiac arrests (excluding A&E)

Improving patient experience

- Documented discussion and agreed plans for End of Life care
- Staff survey response increase participation from 40.4% to 60% and engagement score from 3.7 to national average (future stretch targets to attain a score of 4)
- Reduction of day theatre cancellations by 25%

Improving patient outcomes

- Improve Trust SHMI and HSMR mortality rates
- A comprehensive clinical review process for in-hospital deaths

Our four clinical divisions have each taken these commitments and translated them into quality improvement plans specific to their patients and services. The implementation of these plans will be overseen by our Quality Committee, which is responsible for monitoring quality at the Trust.

We will be reporting on our performance against our quality improvement strategy at our public board meetings throughout 2017/18.
In last year's Quality Account we identified a number of priorities for improvement during 2016/17 to ensure that we continue to raise quality throughout the Trust.

Progress on these priorities as at April 2017 is outlined in the table below.

Improvement priority for 2016/17	Progress as of April 2017
Patient safety	
Medication errors	• The Trust continues to have a very low profile of patient harm associated with medication errors. The number of medication errors reported continues to be high, however in-depth analysis of these incidents has identified that they relate to minor process errors that are picked up by the controls stipulated within the Trust medicines policy.
Patient deterioration	• In May 2016 the Trust established a Deteriorating Adult Group (DAG) for the purpose of focusing on timely and appropriate care to deteriorating patients. Identification of deteriorating patients through use of the National Early Warning Score (nEWS) has increased over the year and the Trust continues to focus upon ensuring that patients whose condition is declining receive the appropriate level of care.
Staff learning through incident feedback	• The Trust has introduced a number of learning initiatives and has continued to work towards enhancing some of the existing mechanisms throughout 2016/17. These include: - Risk Management input into training programmes. - Increased frequency of root cause analysis (RCA) training. - Increased involvement from medical staff in following up incidents. - Monthly Governance Newsletter which is circulated to all matrons, governance leads, care group leads and other senior

Learning from never events outside of theatres	staff. - Introduction of quarterly analysis report – Complaints, Litigation, Incidents, PALS, Inquests (CLIPI) report and Learning from SIs. • Overall the number of reported adverse incidents has increased, based on a comparison with data from 2015/16. The number of SIs declared has decreased, compared with 2015/16. • The Trust has revised the correct site policy to include outside theatre areas in line with the NatSSIP policy. This is now called "Safer Standards for Invasive Procedures" and covers all invasive procedures in and outside theatres. • Learning from Never Events is included in the monthly Governance Newsletter which is circulated to all matrons, governance leads, care group leads and other senior staff.
<u>Patient experience</u> **End of life care** **Complaints**	• Service improvements are being undertaken through information obtained from a comprehensive audit program. A quality improvement program for EOLC services is being implemented in response to issues identified by the CQC. The CQC report emphasised an issue relating to lack of an integrated service. This is an area that is being specifically targeted in terms of improvement. • A Trust wide strategy for EOLC was developed and put into place in November 2016. • A structured EOLC governance framework has been established, confirming the medical, nursing and management leadership. • A detailed implementation plan is in place to support the delivery of the EOLC strategy. • The Trust fully responded to 67% of complaints within 25 working days. Our target is that 85% of complaints are fully responded to within 25 working days. • We fully responded to 89% of complaints within 25 working days or an agreed timescale. Our target is that 100% of

	complaints are fully responded to within 25 working days or an agreed timescale. • Action plans have been put into place in consistently poorly performing divisions within the Trust with the aim of improving and delivering performance against internal standards. • A comprehensive review of the current position is being undertaken and a proposal is being prepared regarding the resetting of targets to take into account the complexity of complaints, improve the quality of responses and better manage complainants' expectations.
Dementia and delirium	• A clinical lead for delirium was appointed within the Trust in November 2016. • A new and improved delirium pathway has also been established. • Just under 7000 Trust staff have completed dementia awareness training, with an overall response rate of 84%.
Patient outcomes **Clinical records**	• Trust performance against national record-keeping standards are good (>85%) for records being bound, organized and ensuring clinical entries are legible, dated and signed. • The Trust has an Information Governance Toolkit rating of 68%. This is satisfactory, but marginally lower than achieved in 2015/16 and needs improvement. • There are still many wards within the Trust that do not undertake mandatory clinical record audits against the national standards – there needs to be a focus on improvement in this area. • A Trust timeline for full implementation of iClip is to be finalised. The Trust will potentially invest in infrastructure over the next 12 months. Once complete, the Trust will commence an iCLIP deployment project, forecast for 2018/19.
Mortality	• For the two major indicators of mortality, the Trust continues to show better than

	expected performance. • Standard Hospital Mortality Rate (SHMR) is 81%, an improvement from 85% in 2015/16. • Summary Hospital Level Mortality Indicator (SHMI) is 0.86, an improvement on 0.91 in 2015/16. • The Trust has fully engaged in the national agenda through participation in the Royal College of Physicians *National Mortality Case Record Review* pilot. • Trust-wide and local processes have been strengthened to ensure deaths are reviewed in a timely fashion. • The Trust has good mortality from trauma and work undertaken on reviews is positive. • On-line screening and review tools have been built, embracing clinical judgement review to enable data collection and capture learning. • These improvements mean that the Trust is in a strong position to implement the national framework *'Learning from Deaths'* during 2017/18.

Reporting against core indicators

Since 2012/13 NHS foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

Further information on the core indicators that are applicable to St George's and performance by each indicator for 2016/17 is available in Appendix G.

Voluntary indicators

NHS Improvement requires the Trust to report on nine voluntary indicators that reflect how we are improving patient safety, patient outcomes and patient experience. We have reported on nine this year, to reflect the services we provide and the patients we care for.

We have worked closely with local stakeholders to identify which indicators to include in this year's quality account, to make sure that the areas that matter most to the people who use and provide our services are covered. The Trust local stakeholders include our council of governors, our local Clinical Commissioning Group (CCG), Wandsworth Healthwatch, Merton Healthwatch, Lambeth Healthwatch and Wandsworth Council.

The table below shows the voluntary indicators reported on in this document, and the indicators that we will be reporting on in next year's quality account (2017/18). These have also been shared with stakeholders for review and input.

The voluntary indicators chosen for 2017/18 reflect some specific issues where the Trust wishes to undertake a bespoke programme of work, or where there is a need to continue to build on work previously undertaken in 2016/17 to support and embed learning in practice.

The indicators we have chosen to include fit into the three essential domains of our quality improvement strategy – *improving patient safety, improving patient experience* and *improving patient outcomes.*

Voluntary indicators in this report for 2015/16	**Voluntary Indicators chosen for next year's report (2017/18)**
Patient safety • Medication errors • Patient deterioration • Staff learning through incident feedback • Learning from never events outside of theatres	**Patient safety** • Improved levels of Early Warning Score documentation identifying patients who are deteriorating – required standard 95% • Rollout of Local Safety **Standards for Invasive Procedures** (LOCSSIPS) to all relevant departments and services • A 25% reduction in patient falls resulting in fractures • No avoidable Grade 4 pressure ulcers • No avoidable in-patient cardiac arrests (excluding A&E)
Patient experience • End of life care • Complaints • Dementia and delirium I	**Patient experience** • Ensure that all patients and their relatives have fully documented discussions and agreed plans for End of Life care • Staff survey response increase participation from 40.4% to 60% and engagement score from 3.7 to national average (future stretch targets to attain a score of 4.) • Reduce on the day theatre cancellations by 25% from 2016/17 levels
Patient outcomes • Clinical records • Mortality	**Patient outcomes** • Improve Trust SHMI and HSMR mortality rates - ensure risk-adjusted mortality remains better than national expected values (SHMI and HSMR), maintaining our 'better than expected' position • Ensure a comprehensive clinical review process for all in-hospital deaths, implementing the Learning from Deaths recommendations (including the openness and publication of mortality data and learning)

Mandatory indicators for auditor assurance

It is a requirement that our external auditors Grant Thornton test certain indicators to provide assurance that there is a robust audit trail within the Trust.

Two indicators are mandatory for the Trust to report against, as set out by NHS Improvement. These are:

1) Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway
2) A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge

One local indicator needs to be selected by the Trust's council of governors. For 2016/17 they have chosen 'Complaints' as their quality indicator for external audit – namely the percentage of complaints responded to within 25 days.

Grant Thornton has been unable to test the NHS Improvement mandatory indicator relating to 'Referral to Treatment' (RTT). Following publication of the findings of the MBI Health Group review in June 2016, the Trust board took the decision to suspend national reporting against the RTT (18 week) standard.
Further information relating to this decision is outlined in the *'Statement of Directors' Responsibilities for the Quality Report'* section of this document.

As the Trust is not reporting against an RTT indicator within the 2016/17 Quality Account, Grant Thornton has tested the *62 day cancer* indicator, in line with NHS Improvement requirements for when one of the mandated indicators is not being reported. NHS Improvement outlines this indicator as:

All cancers: 62-day wait for first treatment from:

- Urgent GP referral for suspected cancer
- NHS Cancer Screening Service referral

Stakeholders

The draft quality account has been shared with stakeholders both for assurance and to increase understanding of the value of the report and how we record the data for each indicator. This quality account has been reviewed by:

- St George's Quality and Risk Committee
- St George's Audit Committee
- St George's Executive Management Team
- St George's Board
- Wandsworth Healthwatch
- Merton Healthwatch
- Lambeth Healthwatch
- Wandsworth CCG
- Wandsworth Council Adult Care and Health Overview and Scrutiny Committee.

Sharing a draft version of the report with our stakeholders has given them the opportunity to provide feedback on our performance in a formal statement. These statements are published in Annex 1.

To put our performance into context, we have compared it for all of the indicators in this report against how we performed over the last two years, and where possible and relevant, against the national

average performance as published on the Health & Social Care Information Centre at: www.hscic.gov.uk

Duty of Candour

'Duty of Candour' formally came into force on 27 November 2014 for NHS Trusts, Foundation Trusts, and Special Health Authorities in England.

The Trust has a legal duty to be open and transparent when there has been either moderate or severe harm to a patient as a result of care received. This process ensures patients receive accurate, truthful information from hospitals and other healthcare providers and also sets out specific requirements that the Trust must follow when there are issues with patient care and treatment.

The Trust implemented a system in November 2016 that positively assures that all patients receive the written notification, setting out the nature of the incident and providing them with both advice on the follow up investigation and how the Trust will communicate with them on the outcome. Since implementation of this system in November 2016, the Trust has fully met its obligations (100% compliance) under duty of candour.

Staff Friends and Family Test (FFT)

Staff who would recommend the Trust as a place to receive treatment and as a place to work to friends or family

Why is this important?

One of the Trust's strategic aims is to be an exemplary employer. To achieve this we must commit time, resources and effort into supporting our staff and making St George's both a place of excellence to receive healthcare and a positive place to work. All of our staff are core to our success and are well-placed to judge the quality of care we provide to our patients.

How did we do?

Every year we conduct the Friends and Family Test within our own workforce. In quarters one, two and four of the financial year we give all Trust staff the opportunity to complete the survey, which comprises of two important questions:

- How likely are you to recommend this organisation to friends or family if they needed care or treatment?

- How likely are you to recommend this organisation to friends or family as a place to work?

Quarter three is given over to the annual national NHS staff survey.

Our scores for 2016-17 by quarter are listed as follows:

	Staff response	Percentage who would recommend for treatment	Percentage who would recommend as a place to work
Q1 April –	655	79%	50%

June			
Q2 July – Sept	534	74%	36%
Q4 Jan - March	403	77%	47%
Full year	1,592	76%	44%

Listening into Action

We recognise that as well as listening to our patients, it is also important that we listen to our staff and involve them as much as possible in identifying where improvements could and should be made across the Trust. The Trust recognises that engagement in this area is an on-going and important priority.

As a result, we are fully engaged with the national *Listening into Action* staff engagement programme. Listening into Action (LiA) launched at St George's in March 2013 and demonstrates the Trust's commitment to working with and engaging all staff at St George's. Listening into Action is focused on achieving a positive shift in the way that the Trust operates and demonstrates leadership, placing our clinicians and staff at the heart of change for the benefit of our patients, staff and the Trust as a whole.

Essentially, Listening into Action is about:

- Engaging the best placed individuals to help deliver better outcomes for our patients, our staff and our Trust
- Aligning ideas, effort and expertise across the Trust to deliver better patient experience, safety and quality of care
- Overcoming widespread challenges that may affect our staff
- Positive and consistent engagement and morale
- Developing confidence and capability in our leaders to help them effectively 'lead through engagement'
- Collaborating across the usual boundaries, and;
- Encouraging a sense of collective ownership and pride across the Trust

Listening into Action complements existing projects and pieces of work that are taking place across the Trust. The change methodologies, systems and experiences that staff develop and gain through Listening into Action is in many cases used to help affect and achieve wider change relating to these projects.

Staff from all departments, levels and roles across the Trust have and continue to work together and talk about what matters to them and what changes should be prioritised. We use staff feedback to inform our future actions and to support and enable our teams to do the very best for our patients and their families in a way that makes us proud of our work.

Listening Into Action is Staff Engagement (LIAiSE)

At the Trust *Big Conversations* in April and May 2013, the idea of providing a dedicated service for staff, based on our Patient Advice and Liaison Service (PALS), was first discussed. The idea was raised by staff at more than one *Big Conversation* and generated much interest. As a result, the

Listening into Action Sponsor Group devised a staff advisory service known as LIAiSE – *Listening into Action is Staff Engagement*. The service is provided by a LIAiSE Adviser who provides a listening and signposting service to Trust staff, identifying where support is available. This service is provided on a one to one, individual, self-referral basis and additionally to teams who request intervention. The LIAiSE Adviser is also the first *Freedom to Speak up* guardian for the Trust.

Values Awards

Our Trust values are designed to inspire our staff and ensure that we keep patients at the heart of everything we do. Both staff and patients can nominate members of staff for one of the Trust's Values Awards – Excellent, Kind, Responsible and Respectful. The Listening into Action Sponsor Group oversees nominations and each month members of staff that are nominated are presented with their award. Each year, all nominees are put forward for the annual Trust Values Awards, which celebrate both an individual and team for each values category.

National NHS Staff Survey 2016

For the 2016 NHS staff survey St George's had an overall response rate of 40%, an improvement from the 2015 score of 31%, which is below the average response for combined acute and community Trusts (42.3%). The range of questions remains consistent from year to year, making it possible to benchmark against previous years as well as against other Trusts. The survey was communicated to all staff via our internal Trust communications channels including our weekly e-newsletter, bi-monthly newsletter and staff forums.

In summary, the Trust performed slightly better than in 2015 but our scores were still lower than the national average for combined acute and community Trusts. Our top 4 ranking and bottom 4 ranking scores are summarised in the table below.

Table 1: Top and bottom four ranking scores for 2016/17

	2015/16		2016/17		
	St George's	National Average	St Georges	National Average	Improvement/ deterioration
Response rate	31%	43%	40.4%	42.3%	Improvement
Top 4 ranking scores					
KF13. Quality of non-mandatory training, learning or development	4.05	4.04	4.10	4.07	Improvement
KF12. Quality of Appraisals	3.04	3.03	3.19	3.11	Improvement
KF18. % of staff feeling under pressure to attend work when not well	57%	58%	53%	55%	Improvement
KF29. % of Staff reporting errors, near misses or incidents witnessed in the last month	88%	90%	91%	91%	Improvement
Bottom 4 ranking scores					
KF19. Organisation and management interest in action on health and wellbeing	3.33	3.59	3.41	3.61	Improvement
KF14. Staff Satisfaction with resourcing and support	3.11	3.72	3.15	3.28	Improvement

KF26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	33%	24%	32%	23%	Improvement
KF10. Support from immediate line managers	3.58	3.72	3.63	3.74	Improvement

For 2017, the Trust has agreed to focus on three key areas:

- Addressing bullying and harassment
- Improving staff engagement
- Improving equality and diversity

Confidence to raise concerns

This year the Trust has improved on the 2015 score for staff feeling secure about raising concerns about unsafe clinical practice but this is still lower than the national average for combined acute and community Trusts. The Trust continues to implement the national *'Freedom to Speak Up'* review. Staff are encouraged to raise concerns and we ensure that they receive support and feedback on the outcome of the complaint. The Trust has also introduced a number of initiatives to improve communication, working practices and team feedback, such as:

- 'Back to the floor fridays' - senior managers go in to the wards and departments every friday to engage with staff and discuss concerns
- Road shows - managers travel to various sites across the Trust and provide updates on a variety of Trust issues e.g. service improvement, Trust finance position, etc.
- 'Schwartz rounds' – allowing staff to discuss the highs and lows of work in a confidential, expertly facilitated environment

Tackling poor behaviour and bullying

In the 2016 staff survey, 32% of staff at the Trust reported harassment, bullying or abuse from other staff and the national average for combined community and acute Trusts was 23%. The score in 2015 was 33%, thus performance in this area has not dramatically increased or decreased.

Tackling poor behaviour, bullying and harassment is one of the key areas that the Trust has agreed to focus on this year. The Trust acknowledges that a fundamental change is required, and amongst a variety of initiatives implemented to tackle bullying (such as reviewing the Trust *Dignity at Work – A policy against Bullying and Harassment*, running unconscious bias training sessions and the Bullying and Harassment support helpline), the Trust has made a decision to engage a Bullying & Harassment specialist. The specialist will provide training sessions across the organisation and at the same time address related issues from minor communication issues between colleagues to perceptions of unfair treatment by management. This decision follows a successful case study of the NHS London Ambulance Service Trust.

Discrimination

The staff survey key questions that are required for the Workforce Race Equality Scheme (WRES) showed that when asked if staff believed that the organisation provides equal opportunities for career progression or promotion, 83% of white staff and 63% of black, minority and ethnic (BME) staff agreed. There was no difference in the score for white staff from last year but the score for BME staff had increased from 59% to 63%. This marked difference between white and BME staff is greater

than that for comparator Trusts where the score is 88% and 75% respectively. The Staff Network Action Group will work to address issues in relation to BME staff and ensure that staff have equal access to opportunities.

Health and Wellbeing

As part of Trust plans to address the health and wellbeing of staff, we are implementing a wellbeing strategy in order to reduce sickness absence and enhance a sense of personal responsibility and engagement amongst staff. In March 2017 we appointed a permanent Staff Wellbeing lead who has developed a wellbeing strategy that includes a wide-range of wellbeing initiatives designed to promote good health. The health and wellbeing lead worked closely with colleagues in the Occupational Health Department, the Chief Executive and the Medical Director to improve the uptake of the flu vaccine achieving 72% vaccination rate for patient-facing staff. We have also employed a physiotherapist to work in our occupational health service to support staff back to work following muscular skeletal absences, and assist them in maintaining good health. Regular Pilates, yoga and other fitness sessions have proved to be a success with staff and these initiatives will continue

Research

Why is this important?

At St George's we are committed to innovating and improving the healthcare we offer. A key way to achieve this is by participating in clinical research. Our clinical staff are fully engaged with the latest treatment developments and through clinical trials patients can be offered access to new treatment interventions, leading to better clinical outcomes for patients.

St George's, in its partnership with St George's University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams are collaborating with scientists to investigate the causes of a range of diseases, to develop better ways of diagnosis and tailored treatments. We look forward to growth in research activity in trauma, neurosciences, cardiology and maternal and foetal health in 2017.

The past year has seen the first phase one study in St George's Clinical Research Facility, testing a therapeutic vaccine in chronic hepatitis B infection. The Clinical Research Facility's infrastructure has improved, with a new laboratory opening which will support clinical trials.

Key to our research is the partnership that the Trust has with St George's University of London. Some major areas of research undertaken in the past year include:

- New diagnostic techniques for tuberculosis
- Understanding the pain pathways in osteoarthritis
- Development of antibiotic dosing guidelines for paediatrics
- Developing MRI scan techniques in cancer
- New physiotherapy techniques for patients with lung disease.
- Evaluation of rapid clinical diagnosis for STIs
- Studies looking at cardiac problems in otherwise healthy individuals
- Identifying new genetic influences in cardiac problems
- Development of non-invasive techniques to predict and prevent pre-term birth
- New treatments for vascular dementia
- Developing a renal inpatient nutrition screening tool
- Improving outcomes of spinal injury trauma patients

- New ECG techniques in inherited heart conditions
- A national study of maternity patient awareness in surgery
- The effects of e-cigarettes on health and well being
- Outcome of very old people in intensive therapy units

In the 2014 Research Excellence Framework, 99% of the research outputs submitted by St Georges and the University of London were judged to be of international standard in terms of originality, significance and rigour. The strongest aspects of clinical medical research were cardiovascular research and cell biology/functional genetics. The strong partnership between St George's and its partner University underpins this excellence.

How did we do?

Participation

A key way to offer new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR), which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. In 2016 St George's recruited 4452 patients onto the NIHR portfolio adopted studies.

Approvals

At St George's in 2016 we had 575 active research studies registered on our database. 318 of these studies were adopted onto the NIHR portfolio. 249 research applications were received in the Joint Research and Enterprise Office (JREO) in 2016 and St George's opened 173 new research studies.

Trials open to recruitment

There is a national target to recruit the first patient to a trial within 70 days of receipt of the study application pack. In the last quarter, 39% of patients met this target.

Ensuring compliance with 'Good Clinical Practice' (GCP) guidelines for research

The International Council for Harmonisation Good Clinical Practice (ICH GCP) has its origin in the Declaration of Helsinki and is a set of guidelines that contains 13 principles, which form a framework to ensure that the safety, rights and wellbeing of trial participants are protected. All trials require a sponsor to take on the legal responsibility to ensure that the trial is conducted safely and gathers good quality information. All of our clinical trials sponsored by St George's are closely monitored by a team from the JREO. When we 'host' studies that are sponsored by other organisations, we undertake our own system of review (audit), in order to ensure best practice and optimal safety for our patients. Every 3 months the JREO randomly selects a number of active studies and clinical trials to audit, to check the study has been conducted in accordance with the standards as described in the ICH GCP guidelines.

Our aims in 2017:

1. **Increase participation**

We intend to maintain and improve upon our patient participation rates in NIHR adopted trials. We will do this through better supporting clinical research in a variety of ways.

We are targeting our CRN budget allocation to the clinical research delivery workforce – those research nurses and coordinators who are the mainstay of clinical trials. We are pro-actively working with the CRN and investigators to identity those trials which St George's can support. The JREO – under new leadership – has implemented a new and improved structure and is streamlining processes to provide optimal support to investigators.

Each year on International Clinical Trials Day, the JREO together with the Clinical Research Facility raise awareness about research by hosting facility tours and inviting potential participants interested in volunteering to studies to add their names to our 'volunteer database'. We are planning the 2017 event for 19 May.

2. Approvals

In 2016, a new governance approval process was introduced by the government in England, hosted by the Health Research Authority (HRA). This new process caused significant delays in activating studies across England and here at St George's. The process is now embedded at St George's and this – along with improved structures and processes - will allow us to increase approvals.

3. Trials open to recruitment

We intend to significantly improve on the number of trials which meet the 70 day target for recruiting the first patient, through improved structures and processes.

4. Ensuring quality

We will aim to audit 10% of all active research studies each year to provide assurance of the safety and quality of studies conducted at St George's. We will continue to support our clinicians to develop their research questions into successful grant applications.

Data quality

Why is this important?

The collection of data is vital to the decision making process of any organisation, particularly at NHS Trusts like St George's. It forms the basis for meaningful planning and helps to alert the Trust to any unexpected trends that could affect the quality of our services.

Staff at the Trust who record patient information have a responsibility to the NHS and to our patients to ensure that all data held electronically or on paper is accurate, complete and captured in a timely manner. Accurate data also ensures improved reporting, up to date statistics, correct invoicing and improved decision making.

How did we do?

Most data is gathered as part of the everyday activity of frontline and support staff throughout the Trust, working in a variety of settings. It is vital that we collectively and accurately capture and record the care that we provide. The information provided below demonstrates how well we do this. Throughout 2017 the Trust has been working closely with our IT suppliers to increase the robustness of both our data capture and processing.

Statistics to show % of Patient Demographic Data captured from SUS (Secondary Users Services)

Note: The data quality figures shown below are correct for 2016/17 to month 11.

			2013/14	2014/15	2015/16	2016/17
	Data Set	National Benchmark	SGH % Valid	SGH % Valid	SGH % Valid	SGH % Valid
	Trust Score	0	90.4	90.8	94.0	94.0
APC	NHS Number	99.2%	98.7%	98.7%	98.0%	97.9%
	Postcode	99.8%	100.0%	99.9%	99.7%	99.5%
	Reg GP Practice	99.9%	100.0%	100.0%	99.8%	99.8%
OP	NHS Number	99.4%	99.4%	99.5%	98.5%	99.1%
	Postcode	99.8%	100.0%	100.0%	99.9%	99.6%
	Reg GP Practice	99.8%	100.0%	100.0%	99.9%	99.9%
A&E	NHS Number	96.4%	93.9%	92.7%	92.3%	93.3%
	Postcode	99.3%	99.8%	99.9%	99.7%	99.9%
	Reg GP Practice	98.8%	99.9%	100.0%	99.4%	99.5%

Overall the Trust figure for NHS numbers remains high, but still marginally short of the National Benchmark set out by NHS England. A high percentage of unrecorded NHS numbers are due to the amount of overseas patients treated by the Trust.

Our aims

St George's University Hospitals NHS Foundation Trust has taken and will be taking the following actions to improve data quality:

- A Data Quality Team was established within the Trust in September 2016 to focus on data cleansing, improving recorded data and reinforcing the importance of data quality to all services across the Trust
- The team work directly with front end users to ensure that they are aware of the importance of capturing good data within our Trust systems.
- The data quality team also work closely with the training team and systems team to ensure that the Patient Administration System (PAS) is robust and that staff are provided with the opportunity to be trained and ask questions
- Data quality dashboards are in the process of being created to monitor how services across the Trust are performing
- The dashboards will inform the data quality team Trust staff and services that require additional support and training

Information governance

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient organisation of services and resources. St George's aims to safeguard patient confidentiality and maintain data security whilst empowering staff within the Trust to perform their role using key information governance principles.

What is Information Governance and why is it important?

Information Governance is the way in which the NHS handles all of its information, and in particular, the personal and sensitive information relating to patients and employees. It provides a framework to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care. It also offers NHS employees a clear structure to deal consistently with the many different rules about how information is handled.

Information Governance Toolkit

The Information Governance Toolkit is a Department of Health Policy delivery vehicle that NHS Digital is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against information governance requirements.

There are different sets of information governance requirements for different organisational types. However all organisations, including St George's, have to assess themselves against requirements for:

- Management structures and responsibilities (e.g. assigning responsibility for carrying out the information governance assessment, providing staff training, etc.)
- Confidentiality and data protection assurance
- Information security assurance
- Clinical information assurance
- Secondary use assurance
- Corporate information assurance

All Health and Social Care service providers, commissioners and suppliers must have regard to the Information Governance Toolkit Standard approved by the Standardisation Committee for Care Information (SCCI).

All organisations that have access to NHS patient data must provide assurances that they are practising good information governance and use the Information Governance Toolkit to evidence this. Where services are commissioned for NHS patients, the commissioner is required to obtain this assurance from the provider organisation and this requirement should be set out in the commissioner-provider contract.

St George's Information Governance Assessment Report overall score for 2016/17 was 68% and was graded a green rating.

The information governance scores for St George's can be found at www.igt.hscic.gov.uk. St George's is listed as an acute Trust and our organisation code is RJ7.

Seven Day Services

Why is this important?

Many patients are admitted to hospitals as emergencies and the treatment they receive in the first hours and days in hospital is crucial. It is also important that patients receive a high level of care no matter what day of the week, or time of the day they need it. A key element of the NHS urgent and emergency care review is that patients requiring services for acute stroke, heart attacks, major trauma, emergency vascular and paediatric intensive care receive consistent, high quality care throughout the seven day week.

The *NHS Operational Planning and Contracting Guidance for 2017-19* (published in September 2016) clearly outlines the ambition that by November 2017, the five network specialist services outlined above meet the four priority standards for seven-day hospital services.

We have been working hard to meet these ambitions by developing our teams and measuring how we are doing against the standards in the five key areas.

What standards are we trying to meet?

First consultant review

All emergency admissions must be seen and receive a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.

Timely access to diagnostics

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Access to consultant directed interventions

Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be:

- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous Coronary Intervention
- Cardiac pacing (either temporary via internal wire or permanent)
- Critical care

On-going review

All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every twenty-four hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

How are we doing?

Our most recent self – audit report (submitted to NHS Improvement) was in September 2016. Whilst we perform reasonably well in most areas there is room for improvement. Nationally we sit just below the average for first consultant review and have been working hard with our teams to make sure that Trust consultants have the time needed in their job plans to be able to see patients in a timely manner.

We will continue to collect data on our performance over the coming year to ensure that we continue to make progress towards our targets.

	Weekday	Weekend
First Consultant review	61%	61%
Timely Access To Diagnostics		
Within 1 hour	92%	66%
Within 12 hours	92%	71%
Access To Consultant Directed Interventions		
Interventional radiology	90%	86%
Interventional endoscopy	95%	90%
Emergency general surgery	100%	100%
Emergency renal replacement therapy	100%	100%
Urgent radiotherapy	73%	39%
Stroke thrombolysis	100%	100%
Percutaneous Coronary Intervention	100%	100%
Cardiac pacing (either temporary via internal wire or permanent)	100%	100%
Critical care	100%	100%
On-going review		
Twice Daily	97%	86%
Once Daily	99%	94%

Data from Trust self-audit report, September 2016

Our aims

Our aim is to work towards fully meeting the standards outlined in the *NHS Operational Planning and Contracting Guidance* by November 2017, for our five urgent networked services. This is a key aim for the Trust and the NHS as a whole, to help deliver care to patients seven days a week.

Mandatory surveillance of healthcare-associated infections

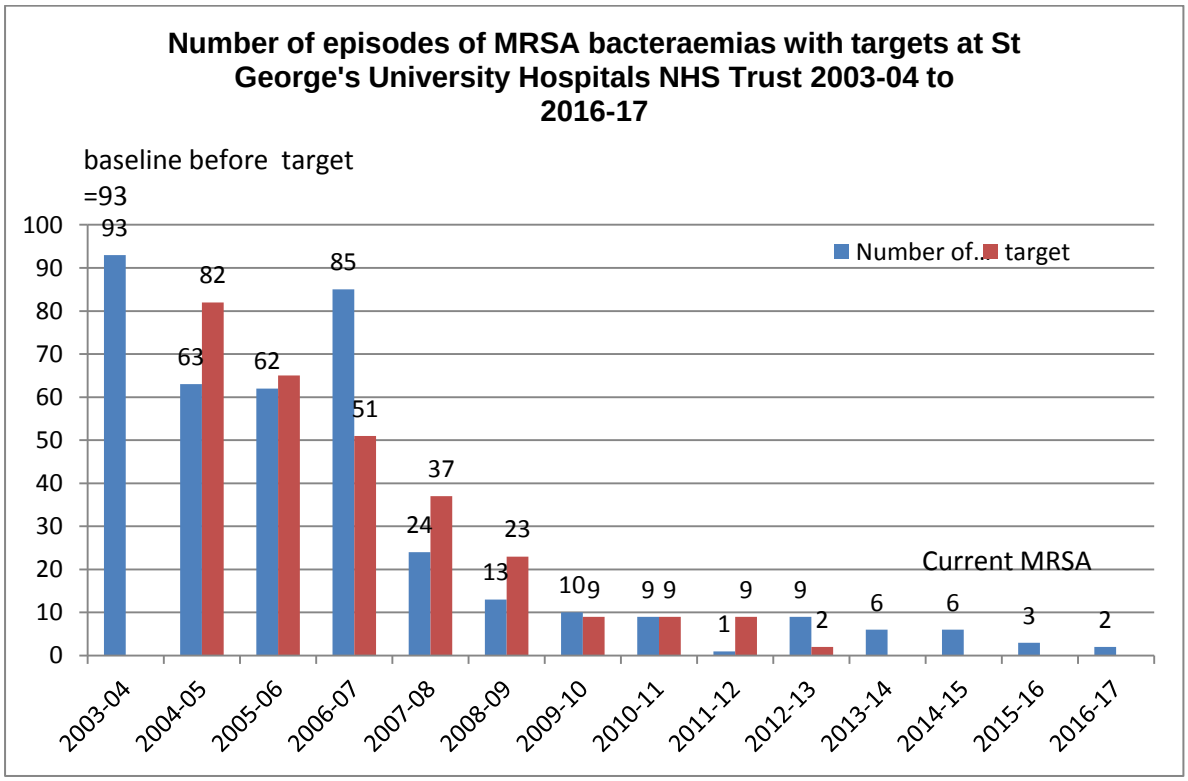
Meticillin-resistant *Staphylococcus aurues* (MRSA) bacteraemia

How did we do?

Since 1 April 2001, all NHS Trusts have been required to report the number of episodes of bacteraemia (bloodstream infection) with MRSA.

In line with the government thresholds, St George's has reduced the number of MRSA hospital assigned bacteraemias significantly since 2002-03, as outlined in the table below. In recent years the number of assigned episodes is as follows:

- 2011/12 - one episode
- 2012/13 - nine episodes
- 2013/14 - six episodes
- 2014/15 - six episodes
- 2015/16 - three episodes
- 2016/17 – two episodes



When compared to other teaching Trusts in London, St George's has low rates of MRSA bacteraemia. These rates are expressed as number of episodes per 100,000 bed days. The rate for 2016-17 was 0.65, which was the lowest for any teaching hospital in London and the sixth lowest for any of the 29 teaching hospital Trusts in England. The worst performing Trust had rates 4 times higher than St George's.

Meticillin-susceptible *Staphlococcus aureus* (MSSA) bacteraemia

How did we do?

From 1 January 2011, NHS Trusts have been required to report all episodes of meticillin susceptible *Staphylococcus aureus* (MSSA) bacteraemia, using similar criteria as employed for MRSA surveillance.

There were 78 episodes in 2016/17 of which 31 were apportioned to the Trust. This compares to 91 episodes in 2015/16 with 39 of these apportioned to the Trust. In 2014-15 the numbers of episodes were 82 and 29 respectively.

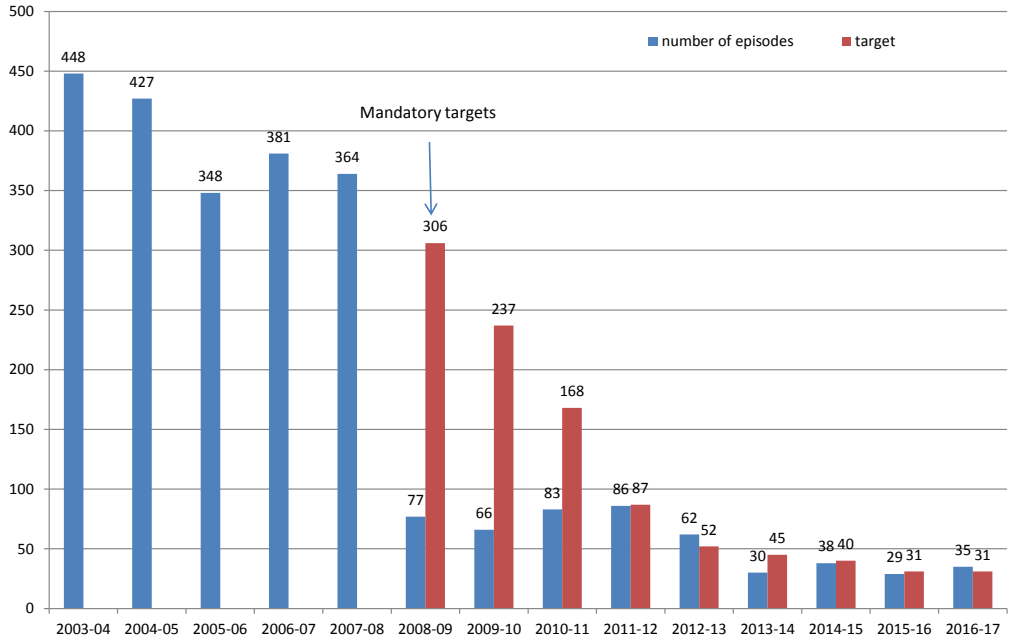
There are no national thresholds for MSSA bacteraemia at present. The 2016-17 rate of Trust-apportioned episodes for St George's is 10.1 per 100,000 bed days and represents the median rate for compared to other similar Trusts in London.

***Clostridium difficile* infection**

Clostridium difficile infection is a major cause of antibiotic-associated diarrhoea, and became widespread in UK hospitals in the late 1990s. In response to this, the Government announced in October 2007 a plan to reduce the number of *C difficile* infections nationally by 30% by the end of the calendar year 2010-11.

Figure 2 indicates the reduction in numbers of episodes since 2002-03. Each year the Trust has a target (threshold) for Trust-apportioned episodes. The targets are individualised for each Trust with a very wide range. The target for St George's in 2016-17 was 31 episodes equating to a rate of 10.2 per 100,000 bed days. Other London Teaching hospital Trusts have targets up to 4 times higher.

Figure 2. Numbers of hospital-acquired infections with *Clostridium difficile* at St George's 2003-04 to 2016-17 with targets



How did we do?

For the first time in three years, the Trust had more episodes of Trust-apportioned *C. difficile* episodes in 2016/17 than the target, i.e. 36 versus a target of 31. This equates to a rate of 11.77 episodes per 100,000 bed days. However the rate for St George's was still lower than the majority of other London Teaching hospitals and was the seventh lowest of all 29 teaching hospital Trusts in England. The best and worst performing Trusts had rates of 8.84 and 33.6 respectively.

Glycopeptide resistant enterococcal bacteraemia

How did we do?

This reporting scheme started on 1 October 2003 and data has been published annually for all hospitals between the months of October to September. St George's figures are illustrated in the table below with figures up to end of September 2016. There are no national thresholds.

St George's has always had very low levels (more than 75% lower than some Trusts) and this trend has continued in the last financial year.

Annual numbers of GRE bacteraemias at St George's Hospital:

Year	Number of patients
October 2009 - September 2010	3
October 2010 - September 2011	4
October 2011 - September 2012	13
October 2012 - September 2013	11
October 2013 - September 2014	12
October 2014 - September 2015	11
October 2015 - September 2016	8

Sepsis

Our aims

Our aim at St George's is to ensure that every patient with sepsis is identified early and has treatment initiated within one hour.

How did we do?

Prior to April 2016 there was no robust system for screening for sepsis in the St George's emergency department or on the wards. During 2016/17, a robust system for screening and early intervention with antibiotics was set up in the emergency department and on four adult wards. Doctors and nurses have also been trained to screen for sepsis and initiate antibiotics early. This training has been supported by the GAPS Simulation centre in the form of the Sepsis 6 course and the Critical Care Liaison project team. A Sepsis Awareness week was also successfully held across the Trust in March 2017.

Sepsis in adults in the emergency department

The Sepsis CQUIN commenced in the Trust in April 2016. Prior to this, there was no robust mechanism to screen for sepsis and no data was collected on screening. Training on screening took place in May and June 2016, with data collection commencing in July.

Figure 1 below shows the marked and encouraging improvement in the percentage of patients meeting the criteria for screening, who were actually screened for sepsis on arrival.

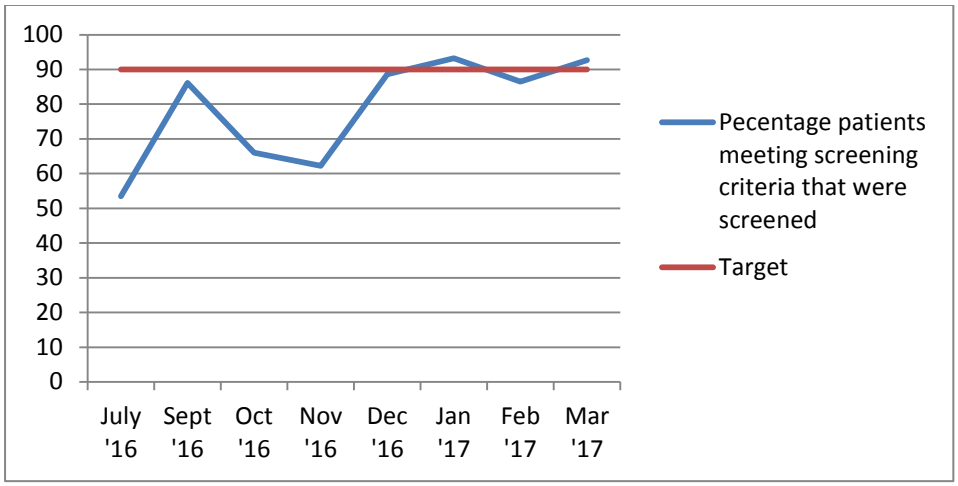


Figure 1: Adult ED patients meeting the screening criteria who were screened on arrival

Antibiotics

An audit of time-to-antibiotics commenced in October 2013. The percentage of adults in the emergency department receiving antibiotics within one hour improved from 25% to 50% by April 2016. With the implementation of the Sepsis CQUIN, the percentage of patients receiving antibiotics within one hour has continued to improve. By the end of March 2017 this figure stood at 86%, as indicated in Figure 2 below.

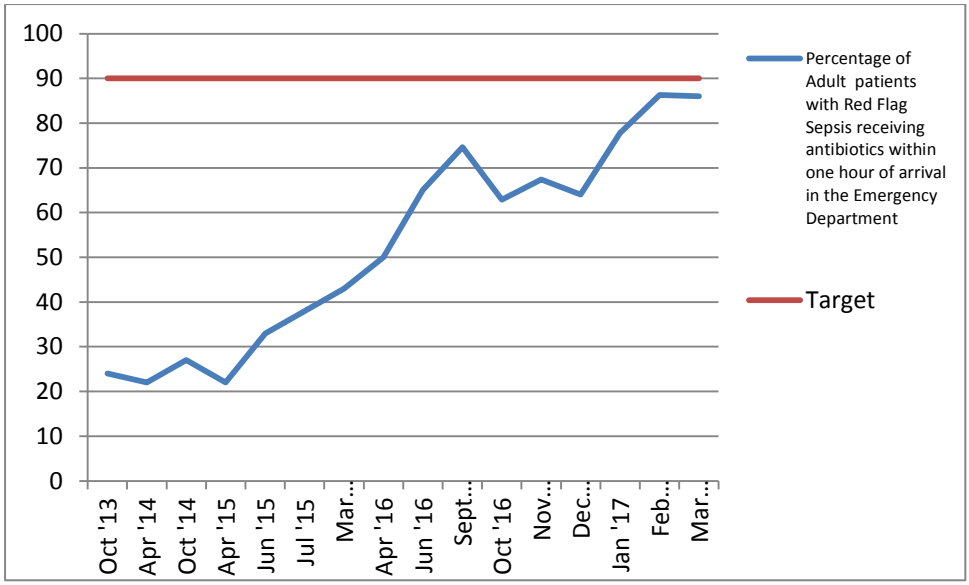


Figure 2: Adult emergency department patients who met Red flag sepsis criteria at triage who received antibiotics within an hour

Sepsis in children in the emergency department

Prior to the implementation of the sepsis CQUIN within the Trust in April 2016, there was no formal system for screening for sepsis nor was there a guideline on sepsis management in children in the emergency department.

No data is available for Q1 of 2016. In Q2, 3 and 4 there were 4, 67 and 105 children respectively, recognised as potentially having sepsis. The number of patients screened improved from 1 in Q2 to 14 and 25 in Q3 and 4, respectively. There were initially issues regarding the logistics and usage of the screening tool. This was resolved by incorporating the screening tool and the Sepsis 6 treatment bundle in the new paediatric emergency department notes.

Approximately 25% of children with sepsis receive antibiotics within one hour of arrival. This is expected to improve with the implementation of the new improved paediatric emergency department notes incorporating the screening tool and the treatment bundle.

Sepsis on the adult wards

Prior to the commencement of the sepsis CQUIN in April 2016, there was no system for screening for sepsis on St George's hospital wards. In Q3 and 4 the Trust invested in three Band 7 Critical Care Liaison Project nurses on 4 wards to screen patients for sepsis and commence treatment. Screening on the wards improved from **0 to 100%** with 1,022 patients being screened for sepsis in Q4. The percentage of patients receiving antibiotics within one hour also improved from 0% to 62.5%.

Sepsis on the paediatric wards

The paediatric wards will be engaged in the Sepsis CQUIN in 2017-18.

Participation in clinical audits

During 2016/17, 50 national clinical audits and 7 national confidential enquiries covered the NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period, St George's University Hospitals NHS Trust participated in 96% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that St George's was eligible to participate in during 2016/17 are listed in Appendix A, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 12 national clinical audits were reviewed by Trust board in 2016/17. A summary of the actions agreed in response to these audits is given in Appendix B.

The reports of 8 local clinical audits were reviewed by St George's in 2016/17. A summary of the actions agreed is given in Appendix C.

Use of CQUIN payment framework

A proportion of St George's University Hospitals NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between St George's and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

As at April 2016, St George's has agreed Q3 performance with commissioners. The Trust currently envisage an 81% overall performance against the suite of CQUINs agreed with commissioners. Estimated income will be £12 million.

Further details of the agreed CQUIN goals for 2016/17 and for the following 12-month period are available in Appendix D.

Payment by Results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

Secondary Uses Service

St George's University Hospitals NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data*:

- Which included the patient's valid NHS number was:
    - 98% for admitted patient care
    - 99.2% for outpatient care; and
    - 93.4% for accident and emergency care

- Which included the patient's valid General Medical Practice Code was:
    - 99% for admitted patient care
    - 99.9% for outpatient care; and
    - 99.6% for accident and emergency care

**Source – SUS Data quality reports as at 17/05/2017*

Improving patient safety

Medication errors

Over the years the Trust has worked hard to develop and maintain its strong reporting culture. Following their audit of the Trust in June 2016, the Care Quality Commission (CQC) reported that staff understood how to recognise and report medicines related safety issues. This is reflected in the higher than average reporting rate of medication incidents at the Trust.

How did we do?

In 2016, the National Reporting and Learning System reported that St George's medication error reporting was higher than the national benchmark for reporting medication incidents. 13.7% of all incidents reported by St George's involved medication, in comparison to 10.8% for all acute teaching organisations for the period of April – September 2016.[1]

In quarters 1-3 of 2016/17, St George's reported 1420 medication incidents, reflecting a good safety culture at the Trust. Of these incidents 94.4 % resulted in no harm, 4.5% in low harm and 1.1% in moderate harm. No medication incidents resulted in severe harm. The most common types of error were omissions and delays to administer medication and administering the wrong dose of medication.

Degree of harm:

No harm – 94.4%

Low harm – 4.5%

Moderate harm – 1.1%

Severe harm – 0%

Trend of reporting medication incidents continued to increase over 2016/17, without an increase in the degree of harm. 94.4% of incidents were no harm in quarters 1-3 of 2016/17, compared to 93.0% for the previous year.

Monitoring

Medicine errors and safety incidents are reported via Datix and these are reviewed by the Trust Pharmacy and the Medicines Optimisation Committee on a quarterly basis. The feedback and learning to staff is communicated through a variety of channels such as newsletters, Trust-wide memos, quarterly meetings with senior nursing staff for each division, divisional governance meetings and face to face meetings with relevant staff.

The Trust pharmacy department has an intensive medication safety teaching programme for clinical staff and our pharmacy team manage a comprehensive audit programme, including auditing prescribing accuracy, medicines reconciliation, antibiotic point prevalence, medication handling and medication safety. The pharmacy medication safety team also co-ordinate medication safety monitoring visits to clinical areas to monitor medication safety issues.

During 2016/17, medication safety visits have been conducted in community services, ward and non-ward areas including radiology and endoscopy.

References:

1. *National Reporting and Learning System (March 2017) Organisation Patient Safety Incident Reports: 01 April 2016 – 30 September 2016; St Georges University Hospitals NHS Trust.*

Patient deterioration

Why is this important?

St George's outreach service is currently provided by staff from a number of departments. Internal National Early Warning Score (nEWS) and global trigger tool audits have identified some shortfalls in care. A number of Serious Incident (SI) reports have suggested patients may have suffered harm or death due to lack of recognition or escalation of acute physiological deterioration.

Additionally, there have been a growing number of potentially avoidable out of hours' referrals to General Intensive Care Unit (GICU). In 2016 'deteriorating adult' was added to the Trust Risk Register and was subject to a 'deep dive' review in a Trust risk meeting in April 2017.

How did we do?

In May 2016, the Deteriorating Adult Group (DAG) was convened to in response to the risk review. The DAG promotes effective and efficient multi-disciplinary care for patients across the trust. This group has wide representation from across the hospital and has highlighted variable practice in some areas of the hospital with regard to:

- Recognition of physiological deterioration
- Local escalation to senior nursing and medical staff
- Lack of routine junior and senior medical input on some wards
- Gaps in consultants review of deteriorating patients
- Poor use treatment escalation plans (TEP) and Did Not Attend (DNA) and Cardio Pulmonary Resucitation (CPR) orders

Our aims

The Trust will provide high quality safe care for every adult inpatient, with the aim of recognising and escalating timely deteriorating patients. The Trust will provide appropriate treatments according to individualised treatment escalation plans. Our aims are to:

- Reduce avoidable cardiac arrest
- Improve individualised in-patient care
- Improve end of life care

Policy

The policy for the Minimum Standard for Adult In-Patient Observation has been updated to improve the processes of recognition, escalation, management and governance and in particular strengthen the escalation criteria.

National Early Warning Score (nEWS) audit

The Trust audited nEWS in January 2017. The results demonstrated continuous improvement. A full report is provided in Appendix E.

Critical care liaison pilot (CCLP)

This six-month pilot funded via the Sepsis CQUIN came to an end on 31 March 2017. The team of three individuals leading the pilot have worked closely with four wards, identifying and introducing measures to address poor ward handover and knowledge of patients scoring a nEWS ≥ 5; poor utilisation of ward whiteboards; poor knowledge of nEWS amongst the HCA group, poor use of treatment escalation plans and Did Not Attend (DNA) and Cardio Pulmonary Resucitation (CPR) orders.

Serious incident (SI) reporting

SI reporting is now a regular item on the Deteriorating Adults Group agenda. New SI's and closed SI's are discussed to ensure Trust wide dissemination of this knowledge. A thematic analysis of the last years SI's is in progress.

Future Strategy

Our future and long term strategy within the Trust is to:

- Increase awareness and local ownership of risk in every ward
- Embed inpatient care and deteriorating adult care into the governance of every care group
- Improve nEWS monitoring and escalating compliance
- Monitor mortality and incidents and feedback locally
- Create safety work climate by supporting wards with training and change
- Reallocate resources where possible ± recruitment
- Achieve 100% SAFER compliance in the wards
- Set individual escalation and end of life plans for every patient admitted to the hospital

Staff learning through incident feedback

Why is this important?

The Trust operates a single electronic incident reporting system for all adverse incidents and near misses. Reporting an incident is one of the most important ways that staff can help the Trust learn from things that go wrong. The Trust also has a responsibility to ensure that feedback should be provided to staff who report incidents.

How did we do?

The incident reporting system provides the following mechanisms to enable prompt feedback to staff regarding incidents:

- Confirmation email sent to staff when incidents are reported
- Email communication function, to allow shared communication regarding incidents
- Automated feedback via email when an incident is closed on the system, providing staff with details of how an incident has been followed up – this function has recently been put into place

The Trust has also introduced a number of other learning initiatives and has continued to work towards enhancing some existing mechanisms throughout 2016/17:

- Risk Management input into training programmes, including the new manager's induction and preceptorship nursing, regarding incidents and serious incidents (SIs)

- Increased frequency of root cause analysis (RCA) training from bi-monthly to monthly to enable more staff to understand the importance of learning from incidents and enhanced involvement in the SI investigation process
- Use of a 'safety huddle' initiative to share learning amongst ward staff in some medical wards
- Increased involvement from medical staff in following up incidents
- Implementation of a job description for governance leads signed off by Medical Board
- A monthly governance newsletter circulated to all matrons, governance leads, care group leads and other senior staff
- Reporting of incident/SI data to Board and Board sub-committees, as well as at divisional level
- Raising awareness of how to gain feedback using CARE folders in wards/departments
- Introduction of quarterly analysis report – Complaints, Litigation, Incidents, PALS, Inquests (CLIPI) report and learning from SIs.

Overall the number of reported adverse incidents has increased across the Trust, based on comparison with data from 2015/16. Higher and, or increased levels of incident reporting is considered as a positive indicator for effective risk management culture and systems in the NHS.

The number of SIs declared has decreased, compared with 2015/16. Observed in parallel, a decline in the number of Serious Incident (SIs) reported in 2016/17, together with an increase in the total reported incidents is a good indication that the organisation is improving from learning gained from adverse incidents.

Our aims

- Creating a culture of shared learning - encouraging openness and candour so that staff feel able and confident to raise concerns
- Promoting a positive change culture in order to become a learning environment
- Zero Never Events
- Introduce specific training programme for SI chairs and panels
- Increased involvement of simulation to support education and learning
- Improve incident reporting feedback on incidents at time of closure

Learning from never events outside of theatres

Why is this important?

It is equally as important to learn from never events that occur outside of theatres, because they can be as damaging and harmful as never events that occur during surgery (e.g. radiation incidents, risk of sepsis with retained swabs in obstetrics, wrong biopsies with missed cancer diagnosis).

How did we do?

The Trust has revised its site policy to display outside theatre areas, in line with the current NatSSIP policy. The policy is now named 'Safer Standards for Invasive Procedures' and covers all invasive procedures inside and outside of theatres.

Quarterly audits on Local Safety Standards for Invasive Procedures (LocSSIPs) have been established and the data is monitored by the Patient Safety and Quality Board.

The Trust is extending the auditable database on LocSSIPs monthly.

There have been zero Never Events outside of theatres at the Trust since December 2015, compared with four in the same period during the previous year.

Learning from Never Events is included in the monthly Trust Governance Newsletter and circulated to all matrons, governance leads, care group leads and other senior staff.

Our aims

- Zero Never Events
- Extending the LocSSIPs database
- Regular audit with eventual aim of rotational peer audit long term

Improving patient experience

End of life care

Why is this important?

End of life care is provided to patients by all of our clinical staff with approximately 1750 deaths per annum for patients under our care in our acute and community services.

'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020' states that:

"End of life care is care that affects us all, at all ages, the living, the dying and the bereaved. It is not a response to a particular illness or condition. It is not the parochial concern of a particular group or section of society. When it comes to death the statistics are stark. 100% of us will die…palliative and end of life care must be a priority.

The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

As people, professionals and local leaders within the health and social care system and our communities, we must commit to these ambitions and to the framework that will enable their delivery."

End of life care affects every part of the Trust, from the neo-natal unit to the mortuary. This type of care is about helping people live as well as possible until death, with dignity and according to their wishes. There has always been good and positive direct patient care at St George's, but improved governance and operational oversight has meant that we can now evidence where things are working well, and areas where we can do better.

How did we do?

We have participated in a number of key audits in recent years and have understood what we need to do in order to continually develop our services to deliver good quality accessible end of life care.

The Care Quality Commission (CQC) rated end of life care at the Trust as 'requires improvement' in 2014. We developed an action plan and work was undertaken across the Trust to improve our services.

The CQC inspected the Trust again in June 2016. In November 2016 we were rated as:

- 'Inadequate' for End of Life care overall
- 'Good' for Caring
- 'Requires Improvement' for Safe and Responsive and;
- 'Inadequate' for 'Well Led' and 'Effective' domains

The CQC highlighted that patients were treated with dignity, kindness and compassion and that there was consistently positive feedback from patients and their relatives about the service.

However, the CQC highlighted that there was no integrated strategy for end of life care within the Trust and no leadership and governance framework to support executive oversight of the community

end of life care services. The CQC also highlighted that there was no evidence of joint working and that there was limited evidence of our ability to demonstrate our performance and/or effectiveness of our care. Additionally, there was no assurance provided to the CQC that our staff had access to appropriate training.

From November 2016 we developed a Trust wide end of life care strategy: *'Patients, Families and Carers First: End of Life Care Strategy 2016 – 2020'.*

We nominated a non-executive board member for end of life care and re-established the end of life care Steering Group with divisional and departmental representation and including external stakeholders. We also developed a structured governance framework and confirmed the medical, nursing and management leadership for end of life care.

We now have a detailed implementation plan in place to support the delivery of the strategy which is divided into time specific milestones for end of life care service development and delivery across the divisions and the Trust as a whole.

From January 2017 the Trust has committed to:

- Reviewing and analysing end of life care related complaints and incidents
- Reviewing staff education and training levels
- Reviewing agreed key performance metrics e.g. the numbers of patients who died in their preferred place of death
- Providing and end of life care related audit and;
- Making recommendations for improvement in practice

Our aims

The Trust end of life care strategy is shaped by *'Getting end of life care right'- South West London Sustainability and Transformation Plans* and is informed by the outcome of the CQC inspection in 2016.

It reflects the six ambitions for end of life care, regardless of age, diagnosis or locality and will be delivered seamlessly by our hospital and community services embracing a multi-disciplinary and multi-agency approach to care. Implementation and delivery will take different forms across different specialities and services and will be reflective of the specific needs of discrete populations, such as children or older people.

Our vision is: *End of life care matters to everybody and that people under our care are able to die with choice and dignity.*

The Trust has detailed the following 6 ambitions which are common to all:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is co-ordinated
5. All staff are prepared to care
6. Each community is prepared to help

We will know we are doing well by successfully delivering the following principle objectives in line with our 6 ambitions:

- Promoting the use of Advance Care Planning to enable people to state their end of life care wishes and ensure they are adhered to. To date each division has developed a local process to identify patients who might be entering the last year of life
- Ensuring high quality end of life care. To date we have developed a Trust wide care plan for last days and hours of life aligned to the five priorities of care for the dying person
- Changing the perception of 'death is failure' to 'a good death is a successful care outcome'. To date we have created a staff and patient communication and engagement strategy and we are participating this year again in the Dying Matters national campaign
- Developing transparent processes for access to rapid response 24/7 end of life care. To date each division has implemented guidance for identification of patients in the last hours and days of life
- Ensuring health and social care professionals have access to appropriate and high quality training and education. To date we have successfully secured Health Education England funding to develop and education framework across the Trust and primary care. We are benchmarking our training content with another London Trust and monitoring the levels of our training activity
- Improving the co-ordination of end of life care between varied providers. To date we have agreed that *Co-ordinate My Care* is the electronic End of Life care record for patients in our care. Our community staff participate in the gold standard framework MDT meetings with GPs and colleagues. Our specialist palliative care team have access to *Co-ordinate My Care* to update and create *Co-ordinate My Care* records. Our community and acute colleagues meet on a monthly basis to discuss individual patient care and End of Life care service development

Complaints

Why is this important?

Last year St George's had more than one million appointments and inpatient stays at our hospitals and in the community. With this number of patients and appointments, we know that there will unfortunately be times when we do not meet the expectations of our patients.

We encourage our patients and their friends, family and carers to let us know when this happens so that we can make the necessary changes that are needed to improve.

As well as working with our staff, patients and their friends, family and carers can also discuss any concerns they have with our Patient Advice and Liaison Service (PALS), who will work closely with them and the service involved to resolve any issues. Complaints and compliments can also be formally submitted to our Complaints Department. We aim to investigate and provide a full response to all formal complaints within 25 working days of the complaint being received or within a longer time-frame if agreed with the complainant.

The lessons learned and trends identified from information collected from our complaints process plays a crucial role in improving the quality of our services and the way in which we engage with our patients and visitors.

How did we do?

In 2016/2017 we received 903 formal complaints, a reduction of 8% compared to 975 complaints in 2015/16. In addition we dealt with 533 informal issues and queries via the Complaints Department and received 701 compliments. The Patient Advice and Liaison Service received 7777 contacts of which 3948 were categorised as concerns.

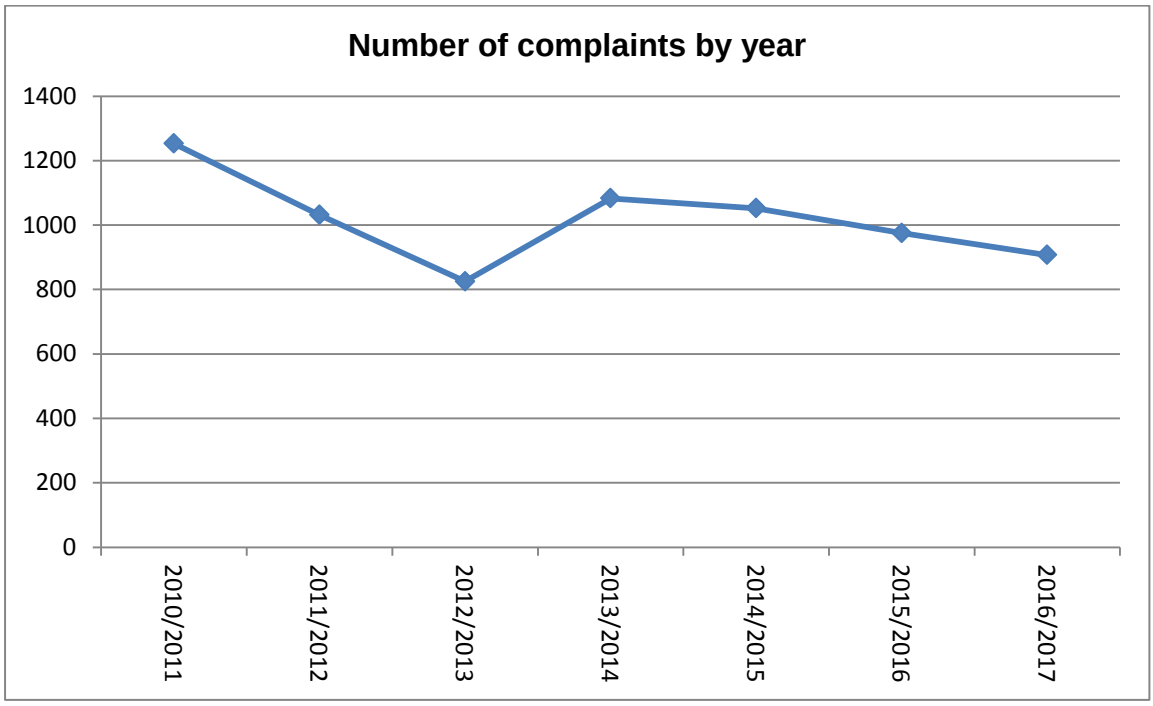
It is currently difficult to benchmark complaints against other Trusts as there is no uniform method for Trusts to record complaints, meaning that there is inconsistency across the NHS.

The Trust views all types of patient feedback as positive and we are consistently assessing how we can encourage patients, carers and families to provide us with their views and feedback.

Number of complaints

Year	Number of complaints
2016/2017	903
2015/2016	975
2014/2015	1052
2013/2014	1083
2012/2013	825

2011/2012	1031
2010/2011	1253



Complaints response rate

The Trust fully responded to 67% of complaints within 25 working days. Our target is that 85% of complaints are fully responded to within 25 working days.

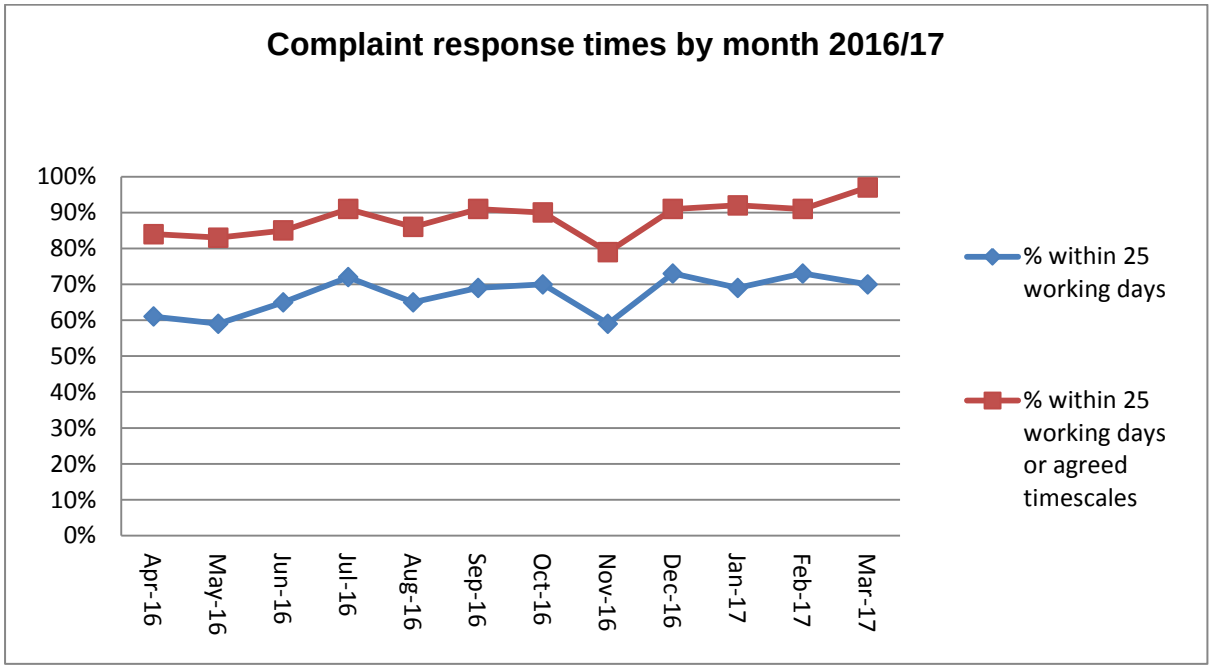
We fully responded to 89% of complaints within 25 working days or an agreed timescale. Our target is that 100% of complaints are fully responded to within 25 working days or an agreed timescale.

The chart below tracks peformance throughout the year. It can be seen that across the year any improvements in peformance against the 85% target were not sustained.

For complaints received in November 2016 performance dipped below 60% for the first time since February 2016. There has, however, been an improvement in responses sent within agreed timescales for complaints received in March 2017.

Action plans have been put into place in consistently poorly performing divisions withn the Trust with the aim of improving and delivering performance against internal standards, but these are not achieving the desired results in some areas.

A comprehensive review of the current position is being undertaken and a proposal is being prepared regarding the resetting of targets to take into account the complexity of complaints, improve the quality of responses and better manage complainants' expectations.


Complaint response times by month 2016/17
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
% within 25 working days
% within 25 working days or agreed timescales

Dementia and delirium

Why is this important?

People living with dementia and/or experiencing delirium are some of our most vulnerable service users. Our focus during 2016/17 has been to bring practice within the Trust in line with the National Institute of Clinical Excellence (NICE) delirium quality standard. This requires us to assess all 'at risk' patients for the presence of delirium, treat delirium appropriately and actively prevent delirium developing in hospital.

To achieve this, we have developed a new delirium pathway which is being implemented across the hospital. In addition, as part of the *Personalised Care Quality Improvement Plan*, we have developed several targets for improving dementia and delirium care in the Trust. We are also committed to listening to carers of people living with dementia through administering and acting on the results of our Dementia Carers Questionnaire. Additionally, we value input from voluntary sector partners, ensuring that the Alzheimer's Society and Wandsworth Carers' Centre are fully represented at the Trust's Dementia Strategy Group.

How did we do?

In recognition of the importance of delirium, the Trust appointed a clinical lead for delirium to work alongside the dementia clinical lead in November 2016.

The nurse-led dementia and delirium team has been supporting the introduction of the new delirium pathway, as well as providing formal and informal training to staff and advising on the care of patients with dementia and/or delirium. Routine referrals of inpatients to the team have increased from an average of 5.4 per week in 2016 (total referrals = 280) to an average of 9.2 per week in 2017 (total referrals to date = 120).

The increase in 2017 does not take into account additional referrals made when the delirium team attended a ward as part of the delirium roll-out strategy (range: 10-20 additional referrals/week).
By 31 March 2017, the new delirium protocol had been introduced on 17 wards, including all general medical, acute surgical and senior health wards. Analysis of routine referrals reveals that 90% come from wards where the new delirium pathway has been introduced, compared to 10% that come from wards awaiting roll-out.

Just under 7000 Trust staff have completed dementia awareness training, an overall response rate of 84%.

In May 2016, 32 wards were assessed using the PLACE (Patient-Led Assessments of the Care Environment), which includes measures of dementia-friendliness. Since then 238 dementia clocks, which help patients to maintain orientation in time, have been distributed to 33 wards. We have also introduced a pictorial food menu to make it easier for patients with communication difficulties to select their preferred drinks and meals.

Responses to the Trust Dementia Carers Questionnaire in 2016/17 show that:

- 86% of carers would recommend the ward where the patient was looked after to friends or family, with similar numbers reporting that they received good communication from staff and felt sufficiently involved in the patient's care plan
- 95% of carers reported that the person living with dementia was treated with dignity and respect

- Two-thirds of carers said that they would like the opportunity to stay overnight with the patient, but only one in five had been able to do this

Our aims

During 2017/18 we will:

- Introduce scorecards to allow individual wards and directorates to rate the quality of their dementia care
- Audit compliance with the new delirium pathway
- Audit use of the *Butterfly Scheme* (our identification and care response scheme for people living with dementia) across the hospital
- Ensure that, where appropriate, ward staff offer dementia carers the opportunity to stay overnight with the person they care for
- Launch a new volunteering role providing activities (such as use of "memory boxes") for inpatients with dementia
- Receive our data from the 2016 National Audit of Dementia, and adjust our dementia and delirium strategy accordingly

Improving patient outcomes

Clinical records

Why is this important?

Health records serve many purposes in the modern healthcare environment, but fundamentally they are the foundation of high quality, safe patient care. Clinical practice in the UK increasingly relies upon the electronic storage and communication of patient records and electronic communication of records. Electronic records make handwriting misunderstandings redundant and facilitate improved communication across the healthcare systems.The Trust is currently in transition with the deployment of iClip (Cerner Millennium) that will eventually mean a fully digital record of the patient's care. In the meantime, the Trust conducts regular audits of existing paper-based health records to monitor the quality of record-keeping against published national standards set by the Royal College of Physicians in 2008. There are still many wards within the Trust that do not undertake mandatory audits against the national standards – there needs to be a focus on improvement in this area.

How did we do?

At present 24 out of 35 Care Groups within the Trust continue to rely on paper-based health records for the care of inpatients. Of the Care Groups participating in these audits, performance against record-keeping standards are good (>85%) for records being bound, organized and ensuring clinical entries are legible, dated and signed.

However, across the Trust poor performance (63%) has been noted for the consultant's name or their team not being recorded in patient health records. Additionally, not making use of the patient labels on the history (continuation) sheet has been noted in approximately 50% of records.

Our aims

Until such time as iClip is fully deployed across the entire Trust, we will continue to monitor and feed back to Care Groups about their existing performance against established standards in record-keeping, to ensure that clinical staff remain aware of the importance of good record-keeping in maintaining patient safety.

The terms of a timeline for full deployment and implementation of iClip are to be finalised. The Trust will potentially invest in infrastructure over the next 12 months or so, i.e. cabling, servers, etc. Once this has been done, the Trust will commence an iCLIP deployment project – forecast for 2018/19.

Mortality

Why is this important?

St George's is committed to understanding mortality data and learning from any care issues in patients who die. The Trust has a well-established Mortality Monitoring Committee, chaired by the Associate Medical Director for Mortality. The membership is multi-professional, with representatives from all divisions and external Public Health. Key corporate functions are also represented to ensure development of consistent approaches to clinical coding and information management.

As defined by the terms of reference the primary purposes of the committee are:

- To monitor and report mortality metrics and consider for investigation areas where we appear to be an outlier
- To review all deaths that occur following elective admission
- To benchmark mortality at a procedure and diagnosis level and to provide oversight of investigations where outcomes appear to be statistically significantly different to the national average or appropriate peer group
- To lead and promote effective governance of mortality within divisions through sharing best practice and implementing Trust-wide protocols
- To promote and support care groups to identify learning and actions from the proportionate review of all their in-hospital deaths
- To engage with the evolving national strategy for measurement and learning from mortality. The committee has fully engaged in the national strategy, and the pilot of the Royal College of Physicians National Mortality Case Record Review Programme

How did we do?

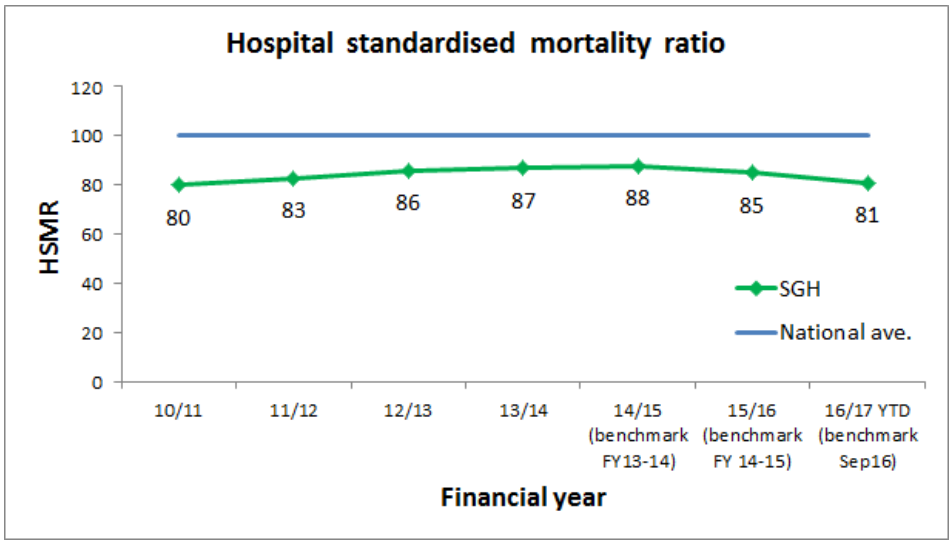
The summary hospital-level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates. It shows whether the number of deaths linked to an organisation is more or less than would be expected, when considered in light of average national mortality figures, given the characteristics of the patients treated there. It also shows whether that difference is statistically significant.

Our SHMI is currently lower than expected. The table below summarises the quarterly publications for this period. As well as considering our overall position we evaluate this data by diagnosis group and investigate areas where mortality may be higher than expected.

Publication date	Reporting period	Ratio	Banding
23 June 2016	January 2015 – December 2015	0.91	As expected
22 September 2016	April 2015 – March 2016	0.90	Lower than expected
15 December 2016	July 2015 – June 2016	0.88	Lower than expected
23 March 2017	October 2015 – September 2016	0.86	Lower than expected

Source: NHS Digital

At St George's we continue to use the hospital Standardised Mortality Ratio (HSMR) in addition to the SHMI to monitor risk-adjusted mortality. The chart below shows our performance over the last six years. With the HSMR, if our mortality matched the expected rate our score would be 100. The HSMR indicates that St George's mortality is consistently significantly better than expected.



Source: Dr Foster Intelligence

Palliative care coding

As it includes all deaths, the SHMI makes no adjustment for palliative care. The Health and Social Care Information Centre publishes contextual indicators to support interpretation of the SHMI, one of which is 'the percentage of deaths with palliative care coding'. This presents crude percentage rates of deaths that are coded with palliative care either in diagnosis or treatment fields.

The data displayed below shows the percentage of deaths with palliative care coding for the Trust compared to the national average.

Publication date	Reporting period	St George's	National
23 June 2016	January 2015 – December 2015	33.4%	27.6%
22 September 2016	April 2015 – March 2016	39.1%	28.5%
15 December 2016	July 2015 – June 2016	42.8%	29.2%
23 March 2017	October 2015 – September 2016	48.9%	29.7%

Source: NHS Digital

Our aims

Learning from Deaths

Following the recent findings of the Care Quality Commission report *'Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England'*, the National Quality Board (NQB) published the first edition of *'National Guidance on Learning from Deaths for Trusts'* in March 2017.

The purpose of the guidance is to help standardise and improve the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers in this process.

St George's has a mature mortality review system and will engage in meeting the requirements of this framework in full. An implementation plan was discussed by the Board in April 2017 and a non-executive director has been appointed to provide oversight of progress.

The framework demands that from April 2017, the Trust collects and publishes on a quarterly basis specified information on deaths, which will include the number of in-patient deaths and those deaths subjected to case record review. Of those reviewed we must report an estimate of how many deaths were judged to be more likely than not to have been due to problems in care. There is a particular focus on vulnerable groups, for example patients with learning disabilities or mental health issues. This data and learning will be published in future Quality Accounts.

30 Day Re-admissions

Why is this important?

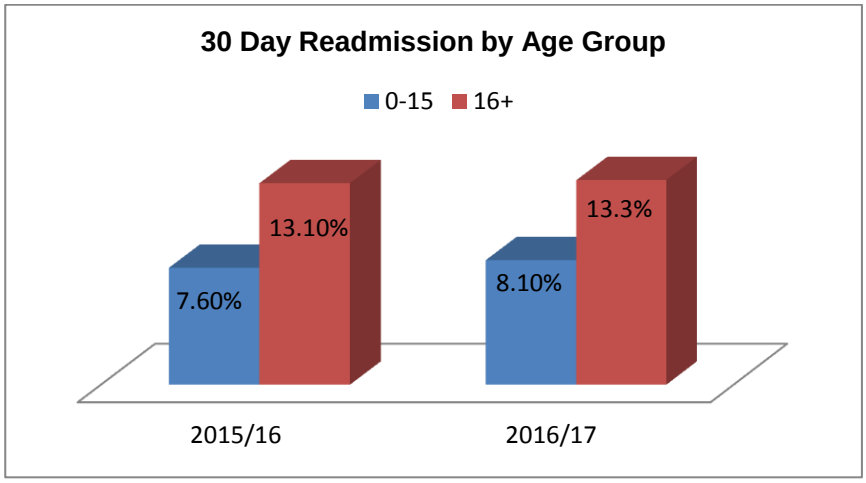
Patients may be readmitted after either a planned or unplanned admission. Some re-admissions are unavoidable but many are avoidable which is why this is used as a measure of quality. Avoidable re-admission can occur for a variety of reasons reflecting care in the hospital, in the community or the transition between them. Avoidable readmissions are undesirable for individual patients and reduce capacity to treat others.

How did we do?

In 2016/17, 12.1% of our patients were re-admitted to hospital within 30 days of discharge. This is a slight deterioration on the previous year when 11.8% of …1patients were re-admitted. We have compared our performance to the national benchmarks and also analysed by age and type of admission.

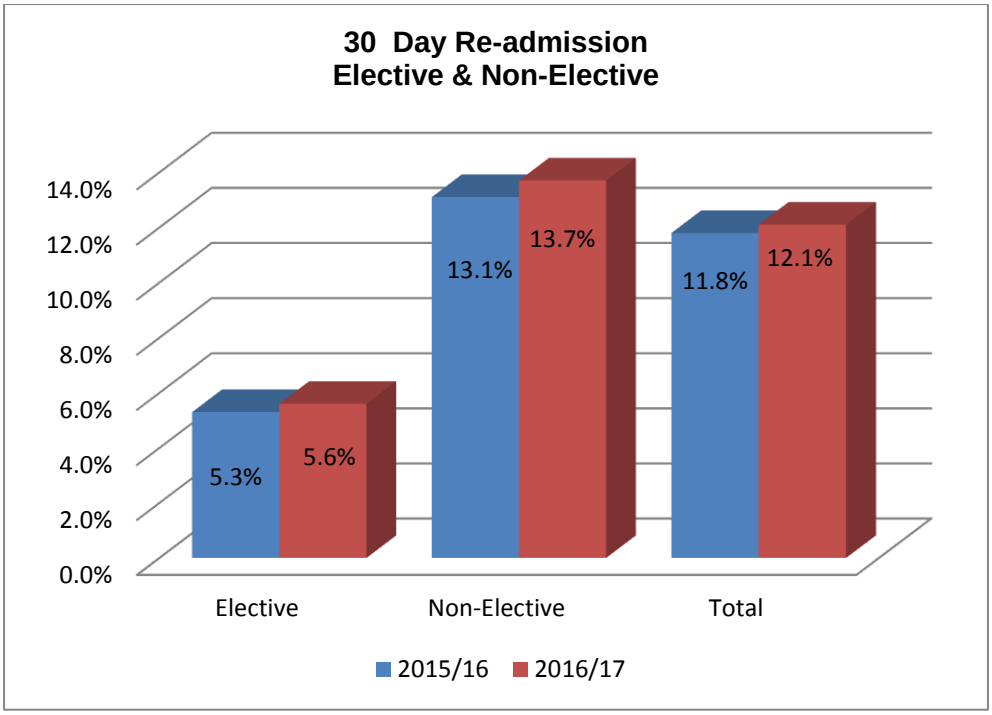
The most recent national data from Dr Foster for the period December 2015 to Nov 2016 shows the national average readmission rate is 6.9% for children* and 9.4% for adults. *Age range on Dr Foster for a child is (0-19yrs). This shows that we have the potential to do better.

Re-admissions do vary depending on the age of the patient. In 2016/17 re-admission rates in the Trust for patients aged 0-15 was 8.1 per cent compared to 13.3 per cent for those aged 16 and over. The comparable figures for 2015/16 were 7.6 per cent for the 0-15 year age group and 13.1 per cent for those aged over 16 years.



Readmission rates also vary depending on whether the first admission was planned or unplanned. In 2016-17 the readmission rate after planned admission was 5.6% (2015-16 figure 5.3%) and after unplanned admission was 13.7% (2015-16 figure 13.1%).

The higher admission rates occurred in patients with diagnosis such as cancers, hematologic conditions, lung disease and mental health disorders.



Our aims for 2017/18

In 2017/18 the Trust is committed to reducing re-admission rates. We will work to ensure that all patients are better prepared for discharge and that there is a coordinated approach with our partners and local authorities to ensuring that the right support is in place following discharge.

Performance table

Theme	Indicator	Target	2014/15	2015/16	2016/17	Rag Rating 2016/17	2017/18
ACCESS	A&E 4 hours waiting time	95%	92.14%	90.4%	91.6%	🔴	Improve and maintain performance in line with trajectory to achieve compliance
	Cancer 14 Day GP Referral	93%	86%	87.8%	89.9%	🔴	Improve and maintain performance
	Cancer 14 Day Breast Symptomatic	93%	95%	93.2%	92.5%	🔴	Improve and maintain performance
	31 Day First Treatment	96%	97%	96.6%	97.2%	🟢	Maintain compliance and ensure performance remains within target
	31 Day First Subsequent Treatment Surgery	94%	96%	96.0%	96.9%	🟢	Maintain compliance and ensure performance remains within target
	31 Day First Subsequent Treatment Drug	98%	98%	100.0%	99.6%	🟢	Maintain compliance and ensure performance remains within target
	62 Day Referral	85%	80%	85.2%	84.7%	🔴	Improve and maintain performance
	62 Day Screening	90%	93%	90.4%	93.3%	🟢	Maintain compliance and ensure performance remains within target
	62 Day Consultant Upgrade	85%	88%	92.7%	94.4%	🟢	Maintain compliance and ensure performance remains within target

Theme	Indicator	Target	2014/15	2015/16	2016/17	Rag Rating 2016/17	
OUTCOMES	Clostridium Difficile	31	38	28	36	🔴	To be compliant and ensure performance within target
	MRSA bacteraemia cases	0	6	9	2	🔴	Zero MRSA incidents.
	Mixed Sex Accommodation	0	16	11	0	🟢	To be compliant and ensure performance within target
	Total number of Never Events	0	5	8	3	🔴	No Never Events in 2017/18
	Mortality	100	Lower than expected levels achieved			🟢	Sustain low mortality rates

Certfication of Compliance Learning Disabilities						
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Yes/No	Yes	Yes	Yes	🟢	
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Yes/No	Yes	Yes	Yes	🟢	Continue to maintain high levels of performance
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Yes/No	Yes	Yes	Yes	🟢	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Yes/No	Yes	Yes	Yes	🟢	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Yes/No	Yes	Yes	Yes	🟢	
Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Yes/No	Yes	Yes	Yes	🟢	

Note: A&E performance reported is avg YTD for April to March 2016/17. Cancer performance reported is YTD for April to March 2016/17

Annex 1: Statements from commissioners, Healthwatch and Overview and Scrutiny Committee

Statement from Healthwatch Wandsworth

Thank you for your letter of 28 April and the draft Quality Account for 2016-17. We very much appreciate the opportunity to comment. I have consulted Healthwatch Wandsworth staff and volunteers, and also sought comments from local Healthwatch colleagues in other boroughs which send patients to Trust services.

This response is submitted on behalf of Healthwatch Wandsworth and Healthwatch Lambeth.

I would like to start with two points which I recognise are obvious but bear brief repetition. First, the Trust and its staff are vital to the health and wellbeing of Wandsworth and its neighbouring boroughs. The committed, sympathetic and professional care which local people receive, day and night, from the Trust's staff is deeply appreciated.

Second, we recognise that in recent years this care has had to be delivered in extremely challenging circumstances. We applaud the resilience and the determination of management, and front-line and support staff, in working through these problems and in striving for improved performance despite all the resource and other constraints that they face.

Proposed quality indicators

We would like to suggest that these be reviewed in order to give a richer range of indicators of patient experience. One indicator relates to the staff survey—we wonder why it is here?—and the others proposed are all process focused. We realise that process indicators can sometimes be more readily measured than outcome indicators, but to cite one example: time taken to respond to complaints is important, but what about the issues being complained about, and how the organisation is learning from them? The NHS category 'Patient Experience', embraces the CQC domains relating to 'Responsive' and 'Caring'. The current proposals seem to relate wholly to the former and we see this as a weakness. One option might be a target relating to conducting Quality Inspections, publishing the results and taking the required action.

Draft Quality Account

Our key point here is that the Trust is required by the CQC to have 'a long term vision and strategy'. We believe that an enduring listening and learning culture, supported by wise and determined governance, is centrally important to this requirement.

There is some evidence in the draft that such a culture is being developed, but it is not yet as embedded or widespread as we would wish and expect to see. The section on complaints (pages 45-7) is, we accept, a summary, but we would have appreciated more depth in the analysis. For all we know, the overall downward trend conceals worsening problems in some areas. That said, one positive example of good practice is on page 48, relating to dementia care, which helpfully reports

feedback from carers about the care being given; and we take some—though limited!—comfort from the inclusion of the 'Learning from deaths' section (page 53).

Conclusion

In short, while we realise that the CQC has highlighted areas for improvement in the patient experience, we would hope and expect that the Trust's own management is making consistent and continuing efforts to find out for itself how this could be improved. That is not clear from the current drafts.

Finally, may I make two linked points about this process. First, I would like to repeat a key point which I made last year,[1] but which is not reflected in this year's document. For a lay reader, such as many of our members, it helps to have things presented clearly: what is the target, why was it chosen, how are you going to measure performance, and ultimately - did you achieve it (why, why not). The current draft reports on a few chosen 'activities', but we have very little narrative explaining how this has improved quality with respect to patient safety, outcomes or experience. Second, we would therefore appreciate the opportunity to contribute to the development of next year's Quality Account at a formative stage.

Dr Clive Norris
Chair, Healthwatch Wandsworth
15/5/17

1 My letter of 16 May 2016

Statement from Wandsworth Adult Care and Health Overview Scrutiny Committee

Whilst this statement is submitted on behalf of the Wandsworth Adult Care and Health Overview and Scrutiny Committee, the tight timescale allowed for its submission means that it has not been possible to agree it at a Committee meeting. The comments made reflect the established view of the Committee and its work over the past year, and have been prepared in consultation with its leading members.

The Overview and Scrutiny Committee recognises that, for the past year, the dominant issue for the Trust has been the CQC inspection which took place in the summer of 2016 and the need to address the ensuing 'inadequate' rating. The Overview and Scrutiny Committee received briefings from the Trust on this at its meetings in September and November 2016 and an update on the Trust's Quality Improvement Plan was circulated to OSC Members in March 2017.

Members' discussion of the CQC inspection focused primarily on three issues:

- The very poor physical condition of some of the facilities at St George's Hospital, and the need to make urgent improvements;
- The weaknesses of the Trust's Information Technology and the resultant failure to apply appropriate clinical prioritisation to patients referred to the hospital for treatment;
- The weaknesses in leadership and the need to establish a permanent leadership team with adequate grasp of quality across the organisation.

Whilst the update on the Quality Improvement Plan provided members with reassurance that actions were being taken in response to the specific issues identified in the CQC inspection, consistent and long-term progress will be required to ensure that the above issues are addressed.

The indicators proposed for inclusion in the Quality Account are consistent with the above and reflect comments that the Wandsworth Overview and Scrutiny Committee has made in its Quality Account statements in previous years:

- The Trust's consistent good performance on mortality has been a strength. It was a concern that the 2015/16 data showed some weakening of performance, but the latest figures indicate that this has been rectified. Nevertheless, it is important that this should be a consistent focus of attention.
- The Trust's failure to achieve national targets on its response to complaints has been a concern to the Overview and Scrutiny Committee for a number of years. It is evident that action to date has not been effective and that an enhanced focus on this issue is required.
- The high number of cancelled operations at St George's has been a concern to the Overview and Scrutiny Committee over a number of years and was identified by the CQC as an aspect of the Trust's performance that was unsatisfactory. The specific target for reduction in cancelled operations is welcome.
- The Overview and Scrutiny Committee noted with concern the sharp drop in staff morale evidenced in the NHS staff survey published in advance of the CQC inspection. It is a serious concern that, over the past year, less than half the staff at St George's would recommend the Trust as a place to work. Accordingly, the commitment to secure improved staff engagement, evidenced through NHS Staff Survey results, is strongly welcomed.

Finally, as noted in previous years, the focus of the Quality Account is largely on the acute services provided by the Trust. We are aware that the Trust was not successful in its bid to continue to provide management responsibility for Community Adult Health Services Wandsworth. The transition of

contractual responsibility for services to a new provider entails a degree of uncertainty and a risk that quality issues will be overlooked. It is essential that this is not allowed to happen, and that the Trust maintains a focus on the quality of these services and works with the new provider to achieve a successful handover.

On behalf of the Adult Care and Health Overview Scrutiny Committee
15/5/17

Statement from Wandsworth Clinical Commissioning Group

There is much focus on process within the report with less than ideal clarity on outcomes. Where outcomes are talked about, it is not clear whether these are the highest priorities for patients or the Trust as a whole. There are many issues raised that are not addressed in terms of a clear explanation. There are also some random statements within the account with no evidence to back them up for example;

- Because SGH treat patients across South west London and as far as East Anglia, they are more likely to have readmissions
- Consultant review that has been undertaken – this mentions 61% of consultants' reviewed. It would be useful to provide context to this statement and also provide more clarity

There is detailed and extensive (indeed more than half of the report) on the nEWS and associated action plans – we feel that this is far too much detail. There is no mention of the RTT backlog/data quality issues /F2FU and Clinical Harm processes despite this being a major quality issue in 16/17. We also expected some discussion of long cancer waits, and the clinical harm review process in general.

Additional points to note in relation to the Quality Account 2016/17 are:

- Staffing levels and safe staffing generally was not covered within the report
- Place to work days in relation to staff - is this symptomatic of what's happening in the Trust generally?
- There are some areas where the Trust mentions gaps and issues, but have stated they are either not going to address or implement - what are the reasons?
- The report mentions 12% of patients readmitted to hospital - how does this compare with other areas?
- Overall the Data Quality section is light on detail
- There is no clear sense of the Trust's quality of services throughout the report
- Very little information is provided on the rationale for next year's priorities
- Many of the actions taken (in the last year) are actually actions to take – and many of these are rhetorical
- Much of the report relates to 2015/16 and has not been updated
- The patient experience section needs to be a bit more comprehensive - should information also be included on the Trust patient survey?

Overall comments

The CCG acknowledges that the Trust is in a transition period with new leadership who are producing this report on work that has taken place prior to joining the Trust. It would be useful if this fact is reflected upon and acknowledged in the executive summary.

The report should be able to highlight 3 key issues:

- What are the key points of learning to reflect on?
- What is going to be the culture of the organisation going forwards to enable issues and gaps to be addressed?
- What are the governance arrangements to enable reporting and delivery of actions?

The Trust should also consider providing a summarised version e.g. in power point, being clear on:

- What the priorities were for the previous year and progress against those priorities
- What the priorities are for improvement in the coming year

Nicola Jones
Chair, Wandsworth Clinical Commissioning Group
17/5/17

Statement from the governors of St George's University Hospitals NHS Foundation Trust

The Council of Governors is pleased to have the opportunity to comment on the Quality Report.

Firstly, we would like to recognise that it has been a difficult year for St George's and that this report is set against a background of the Trust having been placed in special measures for quality of patient care by the Care Quality Commission and in special measures for financial management by our regulator NHS Improvement.

Under these circumstances it has made it more difficult than it should have been for the Council of Governors to exercise its statutory duty to hold the non-executive directors to account. We have been informed that the Trust has embarked on significant improvement plans in terms of the provision of quality of patient care, financial management and sustainability but having heard this before we reserve our opinion on the effectiveness of these plans until we see tangible results. We welcome that the Trust has recently appointed substantively to the Chief Executive, Executive Director of HR and Executive Director of Finance roles and hope that together with our other longer serving board members they will provide the Trust with the stability and leadership that the organisation needs to achieve against its ambitious quality and financial improvement programme.

We therefore hope that the coming year will enable governors to contribute in a more meaningful way.

Governors have welcomed taking part in the internal quality inspections throughout the year and are encouraged that across the Trust patients have responded very positively to questions about their care and those who provide it. We have also welcomed the opportunity to observe committee meetings and provide written feedback where appropriate.

Finally, we would like to take this opportunity to pay tribute to the talented and dedicated staff who we acknowledge have been working in the most challenging circumstances. We recognise that there is much to do but see the steps that are being taken as positive and shall be considering what we can do as a council to support the new phase that the Trust is entering.

Kathryn Harrison
Lead Governor
24/5/17

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance

- The content of the Quality Report is not inconsistent with internal and external sources of information including:

    - board minutes and papers for the period April 2016 to 31 May 2017
    - papers relating to quality reported to the board over the period April 2016 to 31 May 2017
    - feedback from commissioners dated 17 May 2017
    - feedback from governors dated 24 May 2017
    - feedback from local Healthwatch organisations dated 15 May 2017
    - feedback from Overview and Scrutiny Committee dated 15 May 2017
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2016
    - the latest national patient survey dated 2016 (please note the results are under embargo and cannot be published in this report)
    - the latest national staff survey dated 2016
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 25 May 2017
    - CQC inspection report dated 1 November 2016

- The Quality Report presents a balanced picture of the Trust's performance over the period covered

- The performance information reported in the Quality Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- As the Trust is currently not reporting performance against the RTT indicator due to data quality issues, the Trust directors have a plan in place to remedy this as outlined in further detail below. The scale of the issues identified means that it is not possible for Trust directors to say at this time when the Trust will return to full national reporting against the RTT standard.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporate the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

Non-reporting disclosure – Referral to Treatment (RTT)

Following a series of performance and data issues, the Trust commissioned a comprehensive review of the systems and processes in place to manage patients along the elective care pathway. The outcome of the review, conducted by MBI Health Group and endorsed by the NHS Improvement Intensive Support Team, identified multiple operational process and technology issues that highlighted significant risks to the quality of care and safety of patients at every stage of their pathway - whether on RTT pathways or not.

The scale and complexity of the challenge is significant and the review recognised that the Trust had neither the required expertise, nor resources to manage the required corrective action. Following publication of the findings of the MBI Health Group review in June 2016, the Trust Board took the decision to suspend national reporting against the RTT (18 week) standard.

In response to the findings and to implement the recommendations of the review the Trust has established the Elective Care Recovery programme to lead the corrective action necessary to return the Trust to reporting.

Led by the appointment of a Programme Director, the plan comprises six work streams which are necessary to improve the Trust IT systems, data quality and operational processes of tracking and which includes the requirement to validate a significant number of pathways on the Trusts systems. The validation process is complex and it is envisaged will take more than a year to be completed.

It is not expected that the Trust will return to national reporting in 2017/18. The scale of the issues identified means that it is not possible for Trust directors to say at this time when the Trust will return to full national reporting against the RTT standard.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

Jacqueline Totterdell	**Gillian Norton**
---	---
Chief Executive	Trust Chairman
31 May 2017	31 May 2017

Appendix A: Participation in national clinical audits and national confidential enquiries

The national clinical audits and national confidential enquires that St George's University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title		Relevant	Participating	Submission rate (%) / Comment
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		✓	✓	On-going
Adult Asthma		✓	x	This is not included on the mandatory NCAPOP list. We were unable to participate due to a lack of resource.
Adult Cardiac Surgery		✓	✓	On-going
Asthma (paediatric and adult) care in emergency departments		✓	✓	100%
Bowel cancer (NBOCAP)		✓	✓	On-going
Cardiac Rhythm Management (CRM)		✓	✓	On-going
Case Mix Programme (ICNARC)		✓	✓	On-going
Child Health Clinical Outcome Review Programme	Children with Chronic Neurodisability	✓	✓	100%
	Young People's Mental Health	✓	✓	On-going
	Cancer in Children, Teens and Young Adults	✓	✓	On-going
Chronic Kidney Disease in primary care		x	N/A	Not applicable
Congenital Heart Disease (CHD)		✓	✓	On-going
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		✓	✓	On-going
Diabetes (Paediatric) (NPDA)		✓	✓	On-going
Elective Surgery (National PROMS Programme)		✓	✓	On-going
Endocrine and Thyroid National Audit		✓	✓	100%
Falls and Fragility Fractures Audit Programme	Fracture Liaison Service Database	✓	✓	100%
	Inpatient Falls	✓	✓	Data collection for this audit did not take place nationally in 2016/17. We participated in 2015/16

				and have registered to participate in 2017/18.
	National Hip Fracture Database	✓	✓	98.8%
Head and Neck Cancer Audit		✓	✓	On-going
Inflammatory Bowel Disease (IBD) programme		✓	✓	On-going
Learning Disability Mortality Review Programme (LeDeR Programme)		✓	x	This programme was in pilot phase in 2016/17 and we volunteered, but were not selected as a pilot site. Our LD CNS has completed training and we have registered to begin participation from 1st May 2017 as required nationally
Major Trauma Audit		✓	✓	On-going
Maternal, New born and Infant Clinical Outcome Review Programme		✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Non-invasive Ventilation (NIV)	✓	✓	100%
	Mental Health in General Hospitals	✓	✓	100%
	Acute Pancreatitis	✓	✓	100%
Mental Health Clinical Outcome Review Programme		x	N/A	Not applicable
National Audit of Dementia		✓	✓	100%
National Audit of Pulmonary Hypertension		x	N/A	Not applicable
National Cardiac Arrest Audit (NCAA)		✓	✓	On-going
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme		✓	✓	On-going
National Comparative Audit of Blood Transfusion	Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	✓	✓	100%
	Re-audit of Patient Blood Management in Scheduled Surgery	✓	✓	On-going
	Audit of Patient Blood Management in Scheduled Surgery	✓	✓	100%
	Audit of the use of blood in Lower GI bleeding	✓	✓	100%
National Diabetes Audit – Adult	Core Diabetes Audit	✓	✓	On-going

	Foot Care	✓	✓	On-going
	Inpatient Audit (NaDia)	✓	✓	100%
	Pregnancy in Diabetes	✓	✓	100%
	Transition	✓	✓	100%
National Emergency Laparotomy Audit (NELA)		✓	✓	On-going
National Heart Failure Audit		✓	✓	On-going
National Joint Registry (NJR)		✓	✓	On-going
National Lung Cancer Audit (NLCA)		✓	✓	On-going
National Neurosurgery Audit Programme		✓	✓	On-going
National Ophthalmology Audit		x	N/A	Not applicable
National Prostate Cancer Audit		✓	✓	On-going
National Vascular Registry		✓	✓	On-going
Neonatal Intensive and Special Care (NNAP)		✓	✓	On-going
Nephrectomy Audit (BAUS)		✓	✓	On-going
Oesophago-gastric Cancer (NAOGC)		✓	✓	81-90%
Paediatric Intensive Care (PICANet)		✓	✓	100%
Paediatric Pneumonia		✓	✓	100%
Percutaneous Nephrolithotomy (PCNL)		✓	✓	100%
Prescribing Observatory for Mental Health (POMH-UK)		x	N/A	Not applicable
Radical Prostatectomy Audit (BAUS)		✓	✓	100%
Renal Replacement Therapy (Renal Registry)		✓	✓	On-going
Rheumatoid and Early Inflammatory Arthritis		✓	✓	Data collection for this audit did not take place nationally in 2016/17. We participated in all previous years.
Sentinel Stroke National Audit Programme (SSNAP)		✓	✓	On-going
Severe Sepsis and Septic Shock – care in emergency departments		✓	✓	100%
Specialist rehabilitation for patients with complex needs		✓	✓	100%
Stress Urinary Incontinence Audit		x	N/A	Not applicable
UK Cystic Fibrosis Registry		x	N/A	Not applicable

Data notes:

Each audit within a programme has been counted separately. Where ‘on-going’ is stated this implies that the data collection deadline for complete 2016/17 data has not been reached at time of reporting and therefore data submission for the 2016/17 audit period is on-going and cannot be reported.

Appendix B: National clinical audit actions undertaken

The reports of 12 national clinical audits were reviewed by the provider in 2016/17 and St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National clinical audit	Action*
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Details of the report were discussed within the care group. A major concern was the amount of resources required to complete the audit which was complex and used a data collection system that was very unreliable. Locally we have started education to GPs to address the need to mention persistent synovitis in referrals. We offer a DMARD service, and are planning earlier DMARD training for patients, although this is dependent on resources. Issues concerning the audit have been fed back to the BSR and a local audit of practise is underway, as it is felt that the published results of the national project do not present an accurate picture of the service we provide.
Adult Community Acquired Pneumonia (CAP) December 2014 – January 2015	The main recommendations of the audit (with 3 year targets) are: • to increase the proportion of patients who have a chest radiograph within 4 hours of admission to 90% • to increase the proportion of patients who receive their first dose of antibiotic therapy within 4 hours to 85% • to improve the proportion of adults with moderate and high severity CAP administered combination β-lactam and macrolide therapy to 85% • to improve the proportion of coded CAP cases of pneumonia who have a CXR confirmed pneumonia to 85% (i.e. to improve accuracy of diagnosis) These improvements will be facilitated by better use of the CAP care bundle and this has already been adopted within SGH. There will be no national audit in 15/16 or 16/17 but it is anticipated that progress will be monitored in a local audit.
Neonatal National Audit Programme (NNAP): 2015 Annual Report on 2014 data	The report authors note that nationally completeness of data has improved over recent years, and the same appears to be true here with very few data items missing. This improvement is supported by the clinical lead who reviews the regular national data quality reports. Consideration is also being given to whether further resource is necessary to improve data recording, quality and completeness. Many tertiary units have a data manager to manage this audit and that option will be explored.
National Diabetes Inpatient Audit 2015	Results were discussed within the diabetes care group and a monthly meeting introduced to address areas of concern. The full national report and recommendations will further guide actions and response. Commitment to participate in re-audit in 2016.
National Prostate Cancer Audit Second Year Annual Report 2015	Data management system (Infoflex) to be amended to include additional data fields to meet audit requirements. These data fields are to be completed at the MDT both pre and post treatment. One of the MDT co-ordinators is to complete the metrics as patients are

	discussed in the meeting. This should open the door to better BAUS (national urology audit) submissions also. Infoflex to be our hub for these data collections and submissions to prevent double-filling. The current computers and laptops in the Pathology Seminar room to be upgraded to ensure the hardware is up to speed with our requirements and response in real time.
The End of Life Care (EOLC) Audit – Dying in Hospital 2015	The results of the audit together with the requirements of the new NICE guidelines have been discussed by the palliative care team and the End of Life Care Programme Board. Actions have been planned to address any shortfalls in both care quality indicators and organisational quality indicators. These are detailed below. **Care Quality Indicators:** • We are currently above average national average in 4 out of 5 of the clinical indicators, which is very encouraging. Guidance issued at St. George's advises all expected deaths should be referred to the palliative care team, so that we could write an 'individualised EOLC plan'. We will continue to refer all expected deaths to palliative care team and will audit compliance. • To improve our Holistic Assessment of the patient's needs regarding an individual plan of care we have introduced a guidance document to support nursing staff in writing the patients EOLC plan (Daily Nursing End of Life Care Evaluation Guidance). We are in the process of developing an electronic EOL nursing care plan to support nurses in delivering and evidencing the care they give and developing a medical template for EOL that will support clinicians to ensure the care they give is according to NICE guidance and document this in a structured format, once the whole of the Trust has moved to electronic notes. It is hoped that both electronic documents can be 'rolled out' together combined with an education programme provided by the palliative care team. This will depend on the IT strategy and scheduling for the CERNER roll out. • We will audit the use of daily nursing EOLC evaluation guidance in Q3. **Organisational Indicators:** • A board member now fulfils the role of lay member on the Trust Board with a responsibility for EOLC. • As part of the EOLC strategy we are developing an educational strategy, which we anticipate will be completed in Q3. • We are also developing an educational programme for the Trust which will include releasing one CNS per month from clinical responsibilities to devote time to Education and Training. This will include hands on support for staff caring for dying patients. We plan to implement this by Q3. • A survey of bereaved relatives and carers is underway. Initial results will be available in Q3.
National Audit of Percutaneous Coronary Interventions (PCI), January 2014 – December 2014	**Door to balloon time:** local audit is underway to pinpoint exactly where delays are occurring. This will provide us with a better understanding of where improvements are required. **Access:** Practice is changing and recent data shows an improving picture. In February 2016 43% of cases used radial access, this increased to 56% in March 2016 and we will continue to monitor.

	Within St Georges any death following PCI is the subject of a review. Consultant level outcomes which are derived from this national audit and reported publically show that none of the St George's operators have outcomes as measured by the major adverse cardiac and cerebrovascular event (MACCE) rate, which are outside of confidence limits.
Sentinel Stroke National Audit Programme (SSNAP)	Increased consultant presence in ED has reduced the waiting time for patients. The TIA (Transient Ischaemic Attack) clinic has increased its activity by 15% in the last year to help reduce the demand on inpatient beds. Continued work with radiology means most patients get a CT scan in the ED within their first hour in hospital. This year, the Trust expects to launch the first 24/7 thrombectomy service in the country. It took part in trials to evidence that this treatment works and have recently appointed two interventional neuroradiologists who make up a team of five specialists doing the procedure. Thrombectomy removes clots from the arteries of blocked vessels and reduces disability in severe stroke. This service will be offered to patients from SW London and our neuroscience network of partner hospitals in Surrey.
Royal College of Emergency Medicine (RCEM): VTE risk in lower limb immobilisation in plaster cast	Following the Care Group presentation of RCEM results, action plans were drawn up, implemented. Re-audit of VTE documentation was conducted after each implemented change. Step 1 – education of staff (24/11/15) Step 2 – reminder sheet added to each CDU folder (17/02/16) Step 3 – Reminder column added to CDU handover sheet (08/03/16) Step 4 – addition of check box for VTE risk assessment on CDU admission sheet (Due 30/07/16). Audit was conducted at each step and demonstrated that improvements followed each implemented change.
Royal College of Emergency Medicine (RCEM): Procedural Sedation audit	Results show that there is a lot of good practice, but as with the national picture there are improvements to be made and ED have presented results locally and commenced their action plan. • Re-develop procedural sedation proforma. • Create written patient information leaflet. • Create and deliver teaching plan for doctors and nurses – to be given in formal teaching and/or after induction. • Develop schedule for teaching and assessment of procedural sedation competencies for doctors. • Incorporate code for 'sedation' in discharge communications – liaise with clinical informatics/IT.
National Paediatric Diabetes Audit 2014-15	The service continues to explore ways to improve patient education and lifestyle choices to improve personal management. Education of children will be undertaken jointly between the nurse specialist and dietician. There is a newly appointed dietician in post and a new pump review clinic has been established. Missing data on coeliac disease was due to coding issues. This matter is now rectified. Albuminuria rates are low, on-going action reminding patients to present their urine samples. The service prompts patients on need for eye screening and foot management, but do not provide the services.
Royal College of Emergency Medicine (RCEM) Paediatric Vital	**1. Dissemination of results and staff education:** Disseminate results to nursing and medical leads, highlighting issues and lead actions.

Signs	Triage vital signs training and nursing education Reinstate POPS (Paediatric Observation Priority Scores). **2. IT systems, mandatory fields and alerts:** Temp, RR, HR, Oxygen sats, GCS/AVPU & Cap refill mandatory fields on paper light system. iClip Alert on the system for another full set of observations POPS score on iClip as a mandatory field. **3. Monitoring & re-audit:** Regular monitoring of nursing documentation Those with abnormal vital signs to have a further complete set of observations. Re-audit September 2016.

**Based on information available at the time of publication.*

Notes:

At the beginning of quarter 3 the approach to reporting to the Trust board was amended, which has resulted in fewer national audits being reported to the board. This gap has been recognised and a new process is to be introduced in 2017/18 to ensure that all national audits are reported to the Patient Safety and Quality Board in the first instance. This will ensure that due attention is given to all national audit results over the coming year and that any relevant reports can be escalated for Trust board attention.

Appendix C: Local clinical audit actions undertaken

The reports of eight local clinical audits were reviewed by the provider in 2016/17 and St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local clinical audit	Action*
Pre-Operative Fasting Audit – 2016	• Information to Patient Pathway Co-ordinators (PPCs) and Surgical Admission Lounge (SAL) staff around fasting so they can share this with patients more easily. • Change patient information leaflets to emphasize negative impact of prolonged fasting. • More prominent information displayed in SAL about availability of water etc. • Longer term project to improve emergency theatre communication with wards to reduce fasting times. • Re-audit upon completion of action points.
Use of nEWS Re-Audit - January 2016	Individual ward results have been disseminated through the divisional structures. Managers on wards with less than 80% compliance in any of the three main target measures must ensure that staff are adequately educated by their nEWS lead and perform monthly re-audits until compliance has reached 80% consistently. These wards are also to provide an action plan for improvement through nursing board. A PowerPoint presentation is already available to wards for training days and utilised in MEERKAT's training and the Harm Free Care study day. Wards scoring poorly for appropriate response should ensure that staff attend this training. As there continues to be an issue with spacing, particularly at night time, more attention needs to be paid to adhering to documented regularity. Wards that are using the Welch Allyn device are encouraged to seek appropriate training.
Venous Access Device Care Annual Audit Report 2016	Immediate feedback was provided at the point of audit if deemed necessary in the area of VAD management. Overall, there was significant improvement in all areas apart from 'dressing dated' which remained unchanged. On-going actions involve the Venous Access Team continuing to work with the clinical areas to improve documentation of the dressing and highlight suboptimal electronic and paper documentation.
WHO Surgical Checklist Audit 4th Quarter 2015/16 (Peer review audit round)	• Theatres Care Group Lead to present report at local governance meetings to enable discussion and to agree any actions for improvement in compliance. • Summary report to be presented at Theatres Care Group meeting in April 2016 and Division Governance Board. • Matrons and Team leaders to disseminate results and agreed actions at local team meetings. • On-going programme of quarterly audit in all theatre areas.
Bereavement Survey, June 2016	Positive and negative comments have been studied to identify opportunities for learning and improvement. This has provided valuable insight and so it has been agreed that the survey will continue to run, with quarterly analysis to track progress. Furthermore, the survey has been amended so that any relative/carer that would like a response to

	their comments or concerns can provide their contact details. Any such instances will be reported to the End of Life Programme Board so that an appropriate investigation and response can be provided to the bereaved. This will support a positive experience and will also help us to act on any issues in a timely way.
Health Records audit Q1 2016-17	• Patient labels: Continuing to increase the use of patient labels from the current level of 61% is likely to improve the results for patient identifiers on history sheets, in particular the inclusion of the NHS number. • Improve use of dividers in ring folders. • Designation Stamps: Identification of the consultant in charge of the patient's care remains a priority area for action. Using name stamps would improve the recording of name and designation in entries.
Accounting for Swabs, Needles and Instruments - Obstetric Theatres	• The team will continue with re-audit to maintain standards for the 3 of 4 phases that had achieved 100%. • To remind staff on using the accepted method for skin preparation and to re-audit to monitor improvement. • Plan to roll out this audit project to other theatre areas in 3rd quarter of 2016/17.
Annual Consent Audit 2015/16	The audit has been shared with clinical colleagues via the Medical Director, and he is supporting the audit team to identify a clinical lead/group to take this project forward. The audit team would propose to carry out smaller, more regular audits focussed on specific aspects of policy where improvement actions have been agreed.

**Based on information available at the time of publication*

Appendix D: Details of Trust CQUIN schemes for 2016/17

Notes: this information is a forecast from Quarter 3 of 2016/17. Quarter 4 performance is currently being reviewed and approved by our commissioners.

CQUIN Goals and Indicators	Achievement	Comments
National CQUIN schemes		
NHS Staff and Wellbeing • Introduction of staff health & wellbeing initiative (Option 1b) • Healthy food for NHSE staff, visitors and patients • Improving the uptake of flu vaccinations for front line staff within Providers	Partially met	72% against a target of 75% or above for uptake of flu vaccinations.
Timely identification and treatment of Sepsis • Timely identification and treatment for Sepsis in emergency departments • Timely identification and treatment for Sepsis in acute inpatient settings	Fully met	
Antimicrobial Resistance and Antimicrobial Stewardship • Reduction in antibiotic consumption per 1000 admissions • Empiric review of antibiotic prescriptions	Fully met	
Local CQUIN schemes		
Maternity • Maintain 1:27 midwife ratio and 24/7 supernumerary midwife 98% of the time • 144 hours per week consultant cover	Partially met	Consultant cover not achieved in Q1, Q2 and Q3.
Global Trigger Tool • To continue the Institute for Health Improvement Global Trigger Tool with specialty involvement to increase dissemination of learning.	Fully met	
Paediatric Asthma • Meet the London Asthma standards for Acute Asthma inpatient admissions. • Ensure appropriate follow up for children attending ED/PAU at St George's • Develop Outpatient Service for children at High Risk from Asthma • Closer integration of primary and secondary care asthma services • Set up school programme.	Fully met	
Children's Services Improvement Programme (CSIP)	Fully met	

for children who are high users of Emergency department and Paediatric Assessment Unit Achieve system-wide improvement through the adoption of a person and family centred model of integrated healthcare.		
Planned Care Service redesign for Gynaecology, Trauma & Orthopaedics, Elderly care and Urology.	Partially met	Delivery of CQUIN requirements met for Gynaecology, Trauma & Orthopaedics and Elderly care only.
Paediatric Outpatient Parenteral Antibiotic Treatment (POPAT) Establish a paediatric outpatient antibiotic treatment service across all paediatric wards, neonatal unit and emergency department. POPAT will be in line with the national and hospital strategy for the reduction of antimicrobial resistance and hospital acquired infections.	Partially met	Extension not met due to late commencement of Consultant nurse to post in Quarter 3.
Ambulatory Emergency Care (AEC) • To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission are managed to support early discharge in order to free beds • To ensure patients are streamed on presentation directly to AEC following timely assessment in emergency department • To support a standardised model for AEC across SW London so that patients receive the same treatment regardless of location, and ensuring that there is a consistent 7 day a week service in operation	Fully met	
Enhanced cancer consultant nurse provision • Improved access to consultant nurse/key worker support for patients on suspected cancer pathways for lung, gynaecology, urology, head and neck and upper/ lower gastro-intestine • Improved pathway co-ordination and support to patients, particularly on the identified pathways Co-ordination of investigations (particularly when commissioned cross-site) to reduce time from first seen to diagnosis • Redefining the Cancer consultant nurse role to be more patient facing, and less administratively focused • Enhancing the Cancer consultant nurse role, aiding retention and recruitment	Not met	Unable to recruit to post therefore CQUIN not delivered.

Consultant Advice Service (Kinesis) • Incentivise Trust to increase the number of consultants offering a Kinesis advice/consultation service • In key specialties, build a significant sub specialty service Undertake an analysis of the number and type of referrals; the response time; the capacity requirement by individual consultants for types of referrals; the number of Outpatient appointments avoided – as the basis for development of a more sophisticated tariff for 2017-19. Reduction in system costs, cost effective for providers and deliver savings for commissioners. • Gather evidence on the conversion rate for Kinesis referral and outpatient attendance; by specialty • Consider and report on the most cost effective way of managing the interface with diagnostic testing • Develop a Kinesis performance dashboard Gather evidence on the most effective induction for acute consultant staff, education/marketing to primary care and joint workshop sessions that generate the optimal usage of Kinesis to drive improved patient pathways • Align the introduction of Kinesis at the Trust across all SW London commissioners • Be an exemplar for Kinesis across London	Fully met	
Community CQUIN schemes		
Community Adult Health Services • Plan the process as to how the CAHS MDT will be operationalized, and evidence would be collected by working with the new PACT ECP Provider. • CAHS and ECP staff to work together to set-up MDT meetings including required attendance, and develop a checklist to help staff operate weekly MDTs effectively. • Key worker to be made known and entered on care plan. • All care plans to be updated in the MDT and evidence of a plan set for each patient discussed at weekly MDT.	Fully met	
Special Schools Matrix Tool Refining the dataset to incorporate all pupils at all Special Schools, updating the information as each child is reviewed.	Partially met	Some schools have yet to be mapped to

		the matrix tool
Special Schools Clinical Skills Educator • Deliver the necessary range of training/skills so that an increased numbers of Children who qualify for complex care are able to have packages delivered via carers. • Work with the Community Nursing Team to increase the number of children who can have services delivered via carers. • Deliver the training/skills in a cost effective manner to a range of stakeholders including families, care providers, Trust staff and other identified parties. • To ensure that the training/skills give parents confidence in the quality of care that will be provided.	Partially met	No provision of evidence of training plan or provision of details of the number of parents trained.
Learning Disability • Seek to identify people with learning disability, autism and behaviour that challenges who could benefit from receiving a Personal Health Budget by applying specific criteria. • The intention is to improve the experience of service users encourage the development of joint care plans within and across services with service user at the core of the plans.	Partially met	Requirement to provide further evidence to ascertain how many patients have been mapped across both the Trust and the Mental Health Trust.
NHS England CQUIN schemes		
Hepatitis C Virus (HCV) Improving Treatment Pathways through Operational Delivery Networks (ODNs) Joint scheme with Kings College Hospital NHS Foundation Trust. • Governance and Partnership working • Stewardship and NICE compliance	Partially met	NHSE does not consider that the Trust has fully met the requirements of this CQUIN; however in conjunction with Kings this is being disputed by the Trust.
Nationally Standardised Dose Banding Adult Intravenous Systemic Anticancer Therapy (SACT) A national incentive to standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care	Fully met	

across all NHS providers of SACT in England.		
Clinical Utilisation Review • installation and implementation of software; • reduction in inappropriate hospital utilisation; • reporting of results	Not met	The Trust decided not to implement this CQUIN as there was concern that an embedded system with clinical utilisation data capture was already being used. The Trust, along with others tried to get their own in-house system recognised as being accredited for the CQUIN but not one of them was successful as the CUR software has an embedded decision support tool which other systems do not.
Activation System for Patients with Long Term Conditions (LTCs) Development of a system to measure skills, knowledge and confidence needed to self-manage long term conditions, and with that information to support adherence to medication and treatment and to improve patient outcomes and experience.	Not met	The Trust decided not to implement this CQUIN as it was considered that there are already systems in place which this scheme would

		overlap with and therefore the Trust would not be able to realise the benefits the CQUIN required it to deliver.
Optimal Device Maintenance/improvement in the optimisation of device usage during a year of transition to a centralised national procurement and supply chain arrangement through: • the enhancement and maintenance of local systems to assure compliance with national policies and specifications; • the development of local policies to optimise cost effective device usage and ensuring quality outcomes for patients.	Fully met	
Adult Critical Care timely discharge • to reduce delayed discharges from ACC to ward level care by improving bed management in ward based care, thus removing delays and improving flow. • to support the removal of delays of more than 4 hours, whilst continuing to encourage more emphatically removal of delays of more than 24 hours.	Fully met	
HIV Drugs Identify a number of switches of drug regimen making best use of newer forms of antiretroviral drug regimes	Fully met	NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this.
Telemedicine To improve patient experience by reducing the number of times a patient is required to attend a face to face outpatient appointment; but instead has their follow-up care and advice conducted through a non-face to face	Not met	NHS England acknowledged the role of the Trust in the

method.		delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this. The Trust was unable to identify specialties where the number of telephone follow ups could be increased for outpatients which are mostly or wholly commissioned by NHSE. Specifically, Neurology was identified as a possibility but it was found that there was no potential for telephone follow up appointments in this area.
Neo-natal Length of Stay This scheme is designed to improve community nursing support enabling timely discharge for babies <36 weeks gestation.	Fully met	NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentag

		e of the CQUIN value to incentivise the Trust to deliver this.
Other CQUIN schemes to deliver QIPP savings	Partially met	NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this. The Trust was able to demonstrate that savings had been on a number of QIPP schemes but commissioners did not consider these to be of a sufficient value to achieve the requirements of the CQUIN.
Offender Healthcare NHS Staff and Wellbeing • Introduction of staff health & wellbeing initiative (Option 1b) • Healthy food for NHSE staff, visitors and patients • Improving the uptake of flu vaccinations for front line staff	Partially met	Target of 75% of staff receiving flu vaccinations not achieved.
Dental • Recording of data for oral surgery and	Fully met	

orthodontics • Participate in referral management and triage • Participate in Managed Clinical Networks		

Details of Trust CQUIN schemes for 2017/18

CCG schemes Acute and Community schemes (1.5% of total contract value)
• Improvement of health and wellbeing of NHS staff • Timely identification and treatment of Sepsis/reduction in antibiotic consumption • Improving services for people with mental health needs who present to A&E • Advice & Guidance E-referrals • Supporting proactive and safe discharge • Preventing ill health by risky behaviours - alcohol and tobacco • Improving the assessment of wounds • Personalised care and support planning • Children's Services: Matrix Children's Services: Dysphagia Learning Disabilities • Consultant Geriatrician Support to the Community
NHSE Specialist schemes (2.8% of total contract value)
• Hepatitis C Virus • Improving Pathways through ODNs • Medicines Optimisation (includes Iron Chelation/Hep B) • Cancer Dose Banding • IV SACT Complex Device Optimisation • Paediatric networked care • Neonatal community outreach • Improving Haemoglobinopathy pathways • Spinal Surgery Networks Development of Renal home therapies • Neuro-rehab • Paediatric neuro-rehab Homecare - MS drugs HPN audit

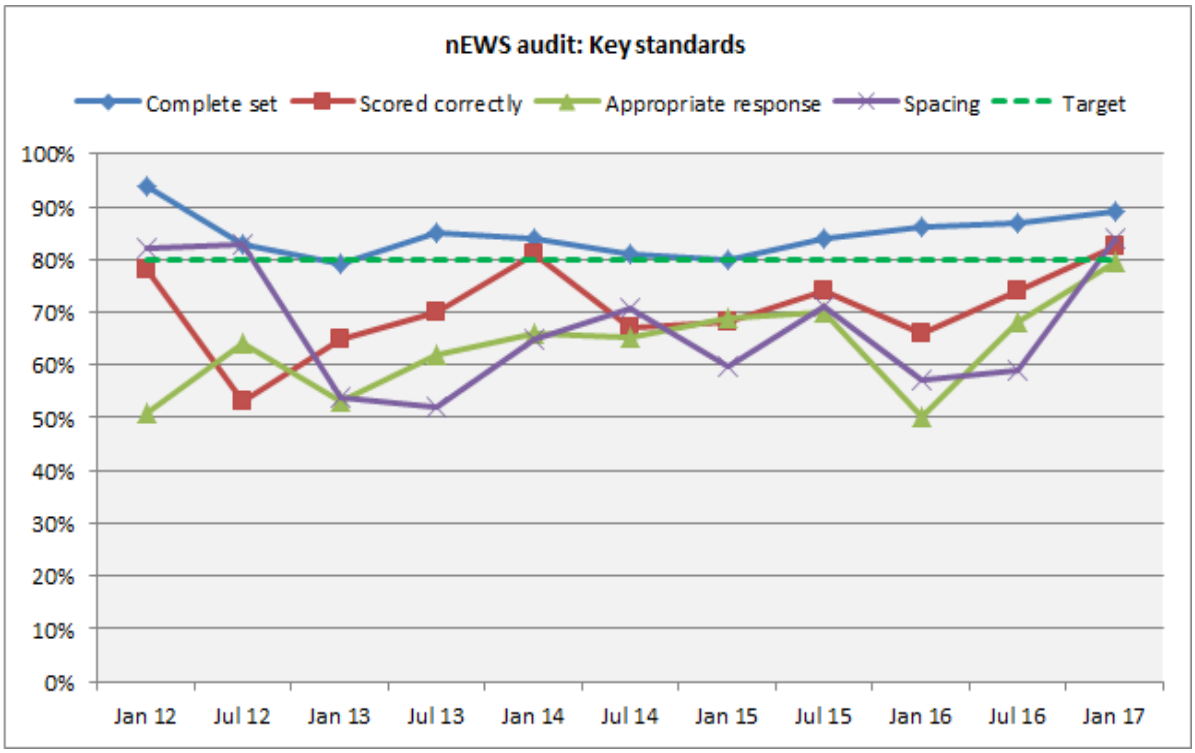
Appendix E: National Early Warning Score (nEWS) Trust audit, January 2017

Summary of results

Main measures of compliance with the National Early Warning Score (nEWS) are summarised in the table below.

Standard	Target	Achieved
Recording a complete set of observations	80%	89%
Scoring nEWS correctly	80%	83%
Appropriate response	80%	80%
Spacing	80%	84%

The following graph shows the comparison with audits conducted since January 2012 when the new version of the nEWS came in to use. There is improvement in all key standards, with the target met across all standards for the first time.



Introduction

NICE states that a graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered locally. To comply with this guideline, St George's has been using EWS chart since 2000 and adopted the national EWS in January 2012.

The chart incorporates a section for reporting concerns using SBAR (Situation, Background, Assessment, and Recommendation). SBAR is a structured mechanism for communicating clinical information, or framing conversations, in order to elicit prompt and appropriate action from another

health professional. The EWS and SBAR tools should help to improve patient care, reduce risk and reduce patient safety incidents, including SIs.

The audit was commissioned by Deborah Dawson, Consultant Nurse Critical Care and Paula O'Shea GICU Liaison Nurse and covered all adult wards in the Trust. At this round of audit the wards using Cerner documentation were also included.

Standards

The current target for each of the criteria audited is 80% compliance. Achieving this standard for complete set of observations and accurate EWS scoring provides evidence of compliance with NICE clinical guideline 50 (July 2007).

Methodology

Thirty four adult wards were included in the audit. For each ward, a number of charts where patients had been on that ward for over 24hrs (where possible) were audited to assess compliance with seven measures. Wards using the CERNER system to record their nEWS (Champneys, Belgrave, Ben Weir and Caroline) were included in this round. Data was extracted from (PIEDW – Power Insight Enterprise Data Warehouse) by an Information Analyst and reviewed by the clinical team.

In the majority of wards 10 patients were audited, but on smaller units this figure was lower. The audit data was collected by a team of senior nurses from critical care, week commencing 9 January 2017.

The full audit criteria were:

1. The chart has a **name**, number [**MRN**]
2. **Regularity** of observations is recorded (where appropriate in line with EWS triggers)
3. Observations are evenly **spaced** throughout the 24 hour period
4. A **full** or **complete set** of observations are recorded on each occasion
5. EWS is **scored correctly** on each occasion
6. Where EWS has triggered, an appropriate **response** is recorded
7. Each set of observations is **signed**

The main measures for the audit were: whether observations are evenly spaced (question 3), whether a complete set of observations was recorded (question 4), whether nEWS was scored correctly (question 5) and, where nEWS has triggered a score, an appropriate response has been documented (question 6). The compliance target was 80% for each of these factors.

Data was directly available from the chart itself with exception of question 6. This required reviewing both nursing and medical notes to check if a response had been recorded. As the patient's nEWS rises it should set off triggers and, various escalation procedures should be implemented. The triggers are divided into low, medium and high risk categories. For audit purposes, we have looked for a cumulative score ≥4 or individual parameter score 3, as these represent patients moving from a low to medium risk category.

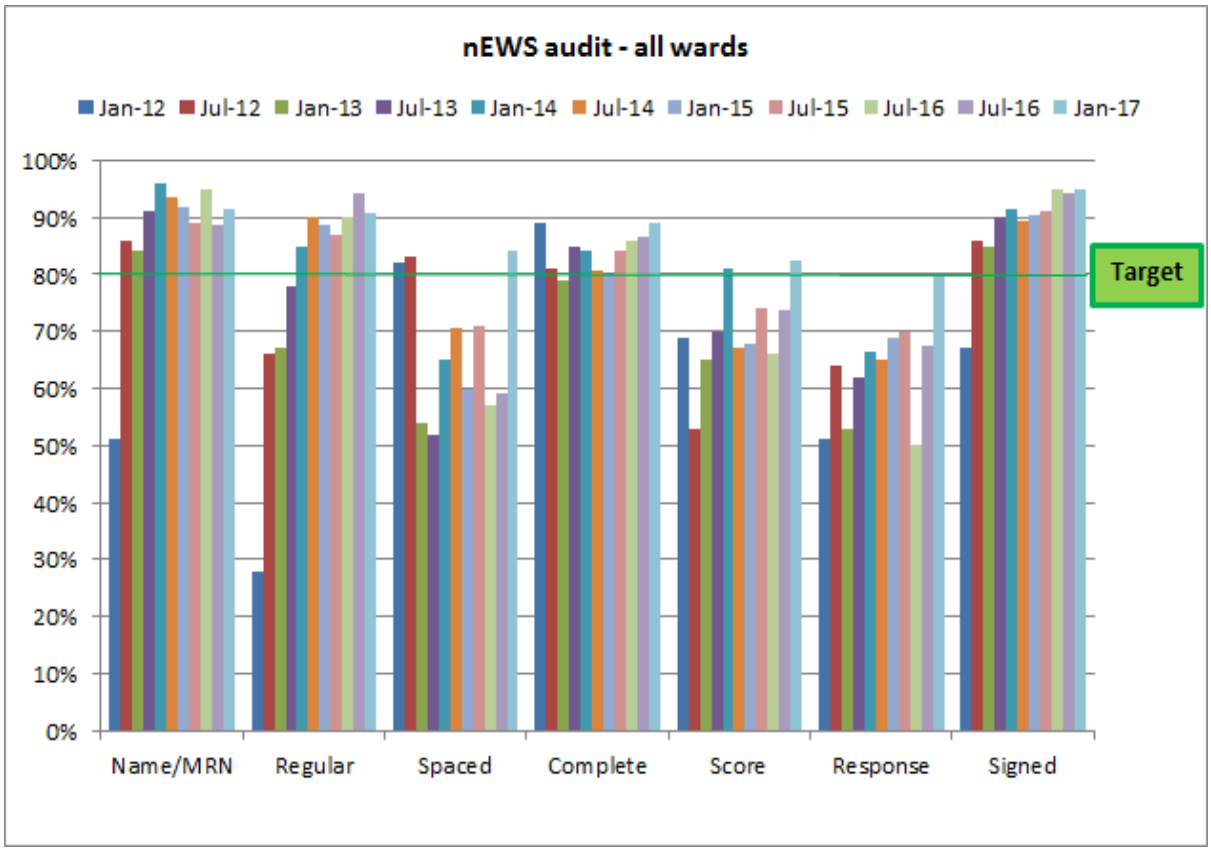
An audit tool was housed on RaTE and data was collected on a combination of paper forms and directly via a tablet. The data was then downloaded and analysed by the clinical audit department.

Results

All adult wards on SGH and QMH were audited. The results for 34 wards, (327 cases), are presented. In this round of audit results for Champneys are compared to Buckland, following the relocation of renal inpatient beds. James Hope was not audited as patients that require an overnight stay are accommodated on the Charles Pumphrey unit, and therefore comparison is between the two areas. The new Nye Bevan unit was audited in place of the Surgical Assessment Unit.

Results for January 2017 compared to previous audits

The following chart summarises the results for all measures and all adult wards. Full achievement of the 80% compliance target is noted for the first time, along with improvement in six out of seven measures. However, the chart also demonstrates variation in compliance between different criteria. There are some elements where best practice appears to be well established, such as recording of patient identifiers and signing of scores; however there are other elements where sustained improvement is sought.



The table below shows results for January 2017 compared to previous audits. RAG ratings have been added, where ≥80% is green, 60-79% is amber and <60% is red.

Audit Period	Name/ MRN	Regular	Spaced	Complete	Score	Response		Signed
January 2017	91%	91%	84%	89%	83%	70/88	80%	95%
July 2016	89%	94%	59%	87%	74%	52/77	68%	94%
January 2016	95%	90%	57%	86%	66%	25/50	50%	95%
July 2015	89%	87%	71%	84%	74%	37/53	70%	91%
January 2015	92%	89%	60%	80%	68%	31/45	69%	90%
July 2014	93%	90%	71%	81%	67%	28/43	65%	89%
January 2014	96%	85%	65%	84%	81%	69/104	66%	92%
July 2013	91%	78%	52%	85%	70%	62/100	62%	90%
January 2013	84%	67%	54%	79%	65%		53%	85%
July 2012	86%	66%	83%	81%	53%		64%	86%

Results for January 2017 by ward

The table below shows percentage compliance for each standard, by ward. RAG ratings have been added, where ≥80% is green, 60-79% is amber and <60% is red. Please see Appendix 1 for ward results over time.

Ward	Name/ MRN	Regular	Spaced	Full set	Score correct	Appropriate Response [1]		Signed	Comments
Allingham (10)	70	100	80	100	100	75	6/8	100	Details missing include hospital number, name, DOB
Amyand (10)	100	90	50	90	70	100	1/1	90	Irregularity mainly at night; in 2 cases frequency should have been changed
Belgrave (10)	100	20	20	90	90	n/a	-	100	Irregularity at night, with no explanation of rationale
Ben Weir (6)	100	17	17	67	67	100	1/1	100	Irregularity at night, with no explanation of rationale
Brodie (10)	100	100	100	80	80	n/a	-	90	
C Hawkins (10)	100	100	90	100	70	100	3/3	80	
Caroline (9)	100	22	22	100	100	0	0/1	100	Irregularity mainly at night, with no explanation of rationale
Cavell (10)	100	100	100	100	100	100	8/8	100	
Champneys (10)	100	90	80	100	100	n/a	-	100	
Charles Pumphrey (7)	100	100	100	71	71	n/a	-	100	
Cheselden (10)	80	90	50	60	50	50	2/4	90	Irregularity at night, with an explanation only given in one case
Dalby (10)	50	100	100	90	80	n/a	-	90	Hospital number missing in 5 cases, and DOB in 1 case.
Florence N (10)	100	90	90	90	70	100	4/4	90	
Gordon Smith (10)	90	100	90	90	80	100	1/1	90	
Gray (10)	90	100	100	100	100	100	2/2	100	
Gunning (10)	100	100	100	80	70	75	3/4	90	
G Holford (10)	100	90	90	100	100	n/a	-	100	
Heberden (9)	100	100	56	78	89	50	3/6	89	Irregularity at night, with no explanation of rationale
Holdsworth (9)	89	100	100	78	67	50	1/2	89	
Keate (9)	89	100	100	89	67	n/a	-	100	
Kent (10)	70	90	50	90	80	14	1/7	100	Details missing include hospital number, name, DOB. Irregularity at day and night.
Marnham (10)	90	100	100	90	90	89	8/9	100	
M Seacole A (10)	70	100	100	90	90	100	1/1	100	Hospital number missing in 3 cases
M Seacole B (10)	70	100	100	100	100	n/a	-	100	Hospital number missing in 3 cases
McEntee (8)	100	100	88	100	88	100	2/2	100	

Ward	Name/ MRN	Regular	Spaced	Full set	Score correct	Appropriate Response [1]		Signed	**Comments**
McKissock (15)	**100**	**100**	**100**	**87**	**80**	**100**	1/1	**93**	
Nye Bevan (7)	**100**	**100**	**100**	**100**	**100**	**100**	2/2	**100**	
Richmond (10)	**90**	**80**	**100**	**100**	**100**	**100**	8/8	**100**	
Rodney Smith (10)	**100**	**100**	**100**	**90**	**70**	**n/a**	-	**100**	
Ruth Myles (10)	**100**	**100**	**70**	**100**	**100**	**67**	2/3	**90**	Irregularity at night, with no explanation of rationale
T Young (10)	**90**	**90**	**100**	**80**	**70**	**n/a**	-	**100**	
T Howell (8)	**100**	**100**	**88**	**100**	**100**	**100**	4/4	**88**	
Vernon (10)	**90**	**90**	**100**	**80**	**50**	**100**	2/2	**90**	
William Drummond (10)	**90**	**90**	**100**	**80**	**50**	**100**	4/4	**90**	
Jan 2017 (327)	**91**	**91**	**84**	**89**	**83**	**80**	70/88	**95**	

***Notes**: (1) "n/a" means that no nEWS was triggered, therefore no response was required or assessed as to whether appropriate.*

Overall there has been improvement in six of seven measures; however, variance between wards is observed. Previously zero compliance with one measure was noted on 5 occasions; this has decreased to 1. Furthermore, 12 wards met the compliance standard of 80% across all measures. Cavell and Nye Bevan achieved full compliance with all standards. Several wards (Cavell, Gray, Mary Seacole B, Nye Bevan and Richmond) achieved 100% in the four main measures; Nye Bevan and Cavell in all seven.

There were improvements in recording of patient identifiers on the nEWS chart, with compliance reaching 91%. 19 wards achieved full compliance. In the 9% of cases (n=28) where name/MRN was missing from the chart the most frequently reported omissions were MRN (26), DOB (7) and name (6). In 9 cases two or more demographic details were missing from the chart.

Scores for regularity of observations decreased slightly, from 94% in July 2016 to 91% at this round. However, spacing of observations improved significantly, from 59% to 84%. At the last round of audit only one ward scored 100% and 13 scored less than 60%; on this occasion 18 wards were fully compliant and 7 scored below 60%. It remains the case that in only a small number of instances was staff able to provide a rationale where there was a discrepancy between the prescribed and observed frequency of observations. As reported previously in a number of cases vital signs were omitted for periods of up to 9 hours, and mostly this occurred overnight.

There was further improvement in recording of a full set of observations on each occasion to 89%. Where a full set of observations has not been recorded it impacts both on the calculation and accuracy of the score. Correspondingly correct scoring also increased, from 74% to 83%. In the 11% of cases (n=36), where a full set of observations had not been recorded the missing details included:

Observation	Temp	HR	BP	Resp	SpO2	Flow rate	Neuro
No. patients missed	11	2	3	11	7	11	10
Frequency missed	1 to 10 times	1	1	1 to 2 times	1 to 2 times	1 to 3 times	1 to 3 times

The appropriateness of the response also improved and the target of 80% was met for the first time since the programme of audit commenced. There remains variation across the wards, but the

proportion scoring 100% has increased from 47% to 63% the proportion rated as red decreased from 41% to 21%. Compliance with the 80% target for the signing of scores was achieved on all wards, with over half reaching 100%.

Divisional results for key measures

Division	Name/ MRN	Regular	Spaced	Complete	Score	Response		Signed
MC (n=167)	92%	85%	73%	90%	84%	41/51	80%	95%
STNC (n=140)	94%	96%	95%	86%	79%	28/36	78%	95%
CSD (n=20)	70%	100%	100%	95%	95%	1/1	100%	100%
ALL (327)	91%	91%	84%	89%	83%	70/88	80%	95%

Actions:

- A target of 80% was set to provide an achievable goal when ten national EWS system was introduced to St George's. The clinical goal should however be 100% in all measures. Some wards have achieved this in most or all measures. Future audits will be measured against this target.
- This report will be discussed by the project team and reported to the Nursing Board, Patient Safety and Quality Board and the Quality Improvement Board for discussion of organisation level results and discussion of required actions.
- The report will also be sent to the divisional leadership teams for distribution and action through the divisional structures
- Ward managers on wards with less than 80% compliance in any of the three main target measures are responsible for ensuring that staff are adequately educated by their nEWS lead. It is suggested that these wards provide an action plan for improvement through nursing board, this should include education and competency assessment of all HCA and RN staff and more regular re-audit. This is the joint responsibility of matrons, ward managers and practice educators in these areas.
- A programme of monthly audit will be launched staring February 2017; this is already being completed by many wards. The programme of 6-monthly audits by an independent clinical team will continue, supplemented by monthly audits conducted by the wards for 5 month periods.
- It was hoped that with the introduction of the Welch Allyn Vital links device, 100% compliance with accurate scoring could be achieved. Wards who are using this device are encouraged seek appropriate training for staff who are using this device**.**
- The Policy for the Minimum Standard for Adult In-Patient Observation has just been updated and is available on the Policy Hub. An awareness campaign will highlight these updates to all staff

Ward level results over time for 3 key measures

RAG ratings have been added, where ≥80% is green, 60-79% is amber and <60% is red. Champneys results prior to 2017 contain results for Buckland, due to the relocation of renal inpatient beds at the end of 2016. In this round James Hope was not audited, as patients that require an overnight stay are now accommodated on the Charles Pumphrey unit, and therefore comparison is between the two areas. The new Nye Bevan unit was audited in place of the Surgical Assessment Unit.

1: Complete Set (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	90	90	80	100	100	50	70	80	100	100
Amyand	90	90	80	60	100	70	70	100	90	90
Belgrave	80	60	70	90	90	60				100
Ben Weir	100	60	60	90	100	90				67
Brodie									80	80
Caesar Hawkins	100		80	70	80	70	80	80	100	100
Caroline	60	80	60	80	50	70				100
Cavell (formerly Gray)	80	60	50	67	90	50	80	80	60	100
Champneys (formerly Buckland)	80	80	100	50	100	100				100
Charles Pumphrey (prior 2017 James Hope)			80	100		40				71
Cheselden	90	60	100	100	90	90	100	90	90	60
Dalby		90	70	80	90	70	50	70	70	90
Florence Nightingale	90	90	90	100	90	90	90	100	90	90
Gordon Smith								90	90	90
Gray (formerly Cavell)	90	90	80	80	90	60	100	80	100	100
Gunning	80	60	100	80	100	100	100	90	90	80
Gwynne Holford		69	60	100	70	90	90	100	80	100
Heberden	90	70	90	100	100	80	60	90	100	78
Holdsworth	100	90	90	100	90	90	100	70	80	78
Keate	80	90	80	90	100	88	100	90	100	89
Kent		100	40	80	90	80	90	90	70	90
Marnham	80	80	90	100	80	50	50	100	80	90
Mary Seacole A			80	100	20	80	80	100	100	90
Mary Seacole B									100	100
McEntee	80	100	80	90	100	100	80	90	90	100
McKissock			40	60	40	90	70	60	60	87
Nye Bevan (prior 2017 SAU)									100	100
Richmond	100	90	60	100	50	70	60	50	90	100
Rodney Smith	100	100	90	90	100	90	100	80	80	90
Ruth Myles	100	80	75		100	100	67	80	100	100
Thomas Young	100	100	80	100	100	100	80	100	60	80
Trevor Howell	100	90	90	90	80	80	50	70	90	100
Vernon	90	100	100	80	70	100	100	100	90	80
William Drummond			80	57	80	80	90	89	88	60
ALL	89	83	79	85	84	80	80	84	87	89

2: Correct score (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	100	80	70	70	100	50	60	90	90	100
Amyand	80	100	60	50	80	60	60	90	80	70
Belgrave	70	30	70	70	90	60				90
Ben Weir	60	10	60	70	90	80				67
Brodie									70	80
Caesar Hawkins	30		50	30	70	70	60	70	80	70
Caroline	70	30	60	30	50	40				100
Cavell (formerly Gray)	50	40	17	67	80	25	70	80	50	100
Champneys (formerly Buckland)	30	60	90	30	100	80				100
Charles Pumphrey (prior 2017 James Hope)			80	100		40				70
Cheselden	30	60	70	90	80	60	80	80	70	50
Dalby		40	50	80	60	70	50	80	60	80
Florence Nightingale	100	60	70	80	90	60	80	90	80	70
Gordon Smith								80	60	80
Gray (formerly Cavell)	90	90	60	50	90	60	80	80	50	100
Gunning	70	40	70	60	100	90	80	70	90	70
Gwynne Holford		58	70	100	100	90	80	90	70	100
Heberden	80	100	80	90	90	40	50	90	80	89
Holdsworth	70	50	90	90	80	90	90	70	70	67
Keate	20	50	40	90	90	88	100	90	100	67
Kent		50	30	60	90	70	60	70	60	80
Marnham	90	10	70	70	70	30	30	90	40	90
Mary Seacole A			100	90	60	80	60	70	100	90
Mary Seacole B									100	100
McEntee	80	100	80	90	100	70	60	50	80	88
McKissock			30	40	30	70	60	30	50	80
Nye Bevan (prior 2017 SAU)									100	100
Richmond	70	50	50	70	50	60	60	40	80	100
Rodney Smith	60	40	90	90	100	90	80	80	80	70
Ruth Myles	80	30	88		100	86	56	50	90	100
Thomas Young	100	70	80	100	100	100	80	100	60	70
Trevor Howell	90	40	60	70	80	40	40	50	90	100
Vernon	60	70	90	60	70	80	90	90	70	50
William Drummond			40	14	80	80	90	89	50	70
ALL	69	53	63	70	81	67	68	74	74	83

3: Appropriate response[1] (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	40	100	0	75	100	67	100	100	100	75
Amyand	67	90	25	0	57	100	n/a	100	33	100
Belgrave	50	0	75	33	0	100				n/a
Ben Weir	25	100	80	50	60	n/a				100
Brodie									83	n/a
Caesar Hawkins	50		100	n/a	25	0	100	N/A	100	100
Caroline	57	100	67	17	67	100				0
Cavell (formerly Gray)	20	n/a	0	33	33	n/a	n/a	50	20	100
Champneys (formerly Buckland)	0	100	33	67	50	50				n/a
Charles Pumphrey (prior 2017 James Hope)			100	n/a		n/a				n/a
Cheselden	25	n/a	50	100	100	67	n/a	100	50	50
Dalby		n/a	0	n/a	33	0	100	50	n/a	n/a
Florence Nightingale	100	50	n/a	75	n/a	100	n/a	100	n/a	100
Gordon Smith								67	100	100
Gray (formerly Cavell)	80	n/a	100	20	100	67	n/a	N/A	40	100
Gunning	25	100	33	71	100	0	100	100	n/a	75
Gwynne Holford		0	20	80	90	n/a	n/a	90	n/a	n/a
Heberden	50	100	50	100	n/a	50	50	0	50	50
Holdsworth	40	100	75	100	33	50	n/a	n/a	0	50
Keate	0	n/a	100	n/a	75	n/a	0	n/a	33	n/a
Kent		100	50	n/a	50	0	100	n/a	71	14
Marnham	100	80	50	50	33	63	50	n/a	33	89
Mary Seacole A			70	90	50	100	n/a	20	n/a	100
Mary Seacole B									100	n/a
McEntee	33	83	n/a	50	n/a	n/a	100	75	0	100
McKissock			n/a	n/a	n/a	0	n/a	n/a	100	100
Nye Bevan (prior 2017 SAU)									n/a	100
Richmond	100	100	86	50	67	100	70	83	100	100
Rodney Smith	25	n/a	0	n/a	25	n/a	50	n/a	75	n/a
Ruth Myles	50	80	n/a		n/a	n/a	n/a	n/a	100	67
Thomas Young	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100	n/a
Trevor Howell	83	50	43	50	100	100	50	100	0	100
Vernon	67	0	100	33	100	100	n/a	n/a	100	100
William Drummond			25	100	100	100	100	50	100	100
ALL	51	77	55	62	66	65	69	70	68	80

1: N/A means that an EWS was not triggered, therefore no response was required nor assessed as to whether appropriate.

Appendix F: Review of services and where our services are based

The services that St George's University Hospitals NHS Foundation Trust provides can be categorised as:

- **National specialist centre**
  We provide specialist care to patients from across the country for complex pelvic trauma, family HIV care, lymphoedema and penile cancer.

- **Tertiary care**
  We provide tertiary care such as cancer services, neurosciences and renal services for the six boroughs of south west London and the counties of Surrey, Sussex and Hampshire. We also provide specialist children's cancer services in partnership with The Royal Marsden NHS Foundation Trust.

- **Local acute services**
  We provide a range of local acute services such as A&E, maternity and general surgery to the people of Wandsworth, Merton, and Lambeth.

- **Community services**
  We provide a full range of community services to the people of Wandsworth, making sure people can manage their health better by accessing the services they need closer to where they live and work and also within their own homes.

Our clinical divisions

Our services are split into four clinical divisions, which all have their own clinically led divisional management boards. Each board has a divisional chair who is an experienced clinician, providing expert clinical leadership to the staff of each service so that the needs of the patients who use them are best met. Every division has a divisional director of nursing and governance who is responsible for nursing, patient experience and making sure that there are strong governance structures within their division for improving the quality of their services and safeguarding high standards of care. Each division also has a divisional director of operations who is responsible for managing the operational, business and logistical aspects of providing healthcare services. The divisional boards are made up of the clinical directors and heads of nursing who are responsible for the specialist services within their division.

Surgery, theatre, neurosciences and cancer division

Surgery and trauma clinical directorate

- Trauma and orthopaedics
- Ear, nose and throat
- Maxillofacial
- Plastic surgery
- Urology
- General surgery
- Dentistry
- Audiology

Theatres and anaesthetics clinical directorate

- Theatres and decontamination
- Anaesthetics and acute pain
- Resuscitation

Neurosciences clinical directorate

- Neurosurgery and neuroradiology
- Neurology
- Neurophysiology
- Neurorehabilitation
- Pain clinic

Cancer clinical directorate

- Cancer

Medicine and cardiovascular division

Emergency and acute medicine

- Emergency department
- Acute medicine and senior health

Specialist medicine

- Lymphoedema
- Infection department
- Rheumatology
- Diabetes and endocrinology
- Chest medicine
- Endoscopy and gastroenterology
- Dermatology

Renal, haematology and oncology clinical directorate

- Renal transplantation
- Renal
- Medical oncology
- Clinical haematology
- Palliative care

Cardiovascular clinical directorate

- Cardiology
- Cardiac surgery
- Vascular surgery
- Blood pressure unit
- Thoracic surgery

Children's and women's diagnostics, therapeutics and critical care

Children's directorate

- Paediatric surgery
- New born services and NICU
- PICU
- Paediatric medicine

Women's directorate

- Gynaecology
- Obstetrics

Therapeutics

- Adult critical care
- Therapies
- Pharmacy

Diagnostics

- Clinical genetics
- Breast screening
- Pathology
- Radiology
- Laboratory haematology

Outpatients

- Outpatients

Community services

Community adult and children's directorate

Community adult health services

- Trauma and orthopaedics
- Ear, nose and throat
- Maxillofacial
- Plastic surgery
- Urology
- General surgery
- Dentistry
- Audiology

Children and family services

- School and special school nursing
- Children's continuing care
- Health visiting

- Child safeguarding team
- Children's therapies and immunisation
- Homeless, refugees and asylum seeker team

Adult and diagnostic services

- Outpatient services
- Minor injuries unit
- Diagnostics
- Specialist rehabilitation
- Adult therapies – physiotherapy, dietetics and
- podiatry
- Integrated sexual health

Offender healthcare

- Primary care
- Substance misuse
- Inpatient care

Where our services are based

Hospitals

We provide healthcare services at:

- St George's Hospital
- Queen Mary's Hospital

Therapy centres

- St John's Therapy Centre

Health centres

- Balham Health Centre
- Bridge Lane Health Centre
- Brocklebank Health Centre
- Doddington Health Centre
- Eileen Lecky Clinic
- Joan Bicknell Centre
- Nelson Health Centre
- Stormont Health Centre
- Tooting Health Clinic
- Tudor Lodge Health Centre
- Westmoor Community Clinic

Prisons

- HMP Wandsworth

Community

We also provide services in GP surgeries, schools, nurseries, community centres and in patients' own homes.

Find out more about our services and the clinicians and healthcare professionals who provide them on the services section of our website at: www.stgeorges.nhs.uk/services.

Appendix G: Reporting against core indicators

The following core indicators are applicable for St George's University Hospitals NHS Foundation Trust:

- The value and banding of the summary hospital-level mortality indicator (SHMI)
- The percentage of patient deaths with palliative care coded at either diagnosis or speciality level
- The percentage of patients aged 0-15 and 16 or over re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust
- Responsiveness to the personal needs of patients
- Friends and Family Test for staff
- Venous thromboembolism (VTE) risk assessment rates for patients
- Chlostridium difficile infection rates
- Patient safety incidents

The tables below set out the Trust indicator performance for 2016/17 and 2015/16, the national average for the indicator as well as the indicator values at NHS Trusts and foundation Trusts with the highest and lowest performance for the same indicator.

Indicator	Reporting period	Ratio	Banding	National Average	Highest/lowest performance for other NHS Trusts
Value and banding of SHMI (summary hospital-level mortality indicator) for the Trust for the reporting period.	**January 2015 – December 2015** **April 2015 – March 2016** **July 2015 – June 2016** **October 2015 – September 2016*** ***January 2016 – December**	**0.91** **0.90** **0.88** **0.86**	**As expected** **Lower than expected** **Lower than expected** **Lower than expected**	**1.00** **1.00** **1.00** **1.00**	**0.67** **1.17** **0.68** **1.18** **0.69** **1.17** **0.69** **1.16**

	2016 data to be published by NHS Digital 22nd June 2017				

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is scrutinised by the Mortality Monitoring Committee and validated through the examination of additional data sources including daily mortality monitoring drawn directly from hospital systems and monthly analysis of Dr Foster data

St George's University Hospitals NHS Foundation Trust intends to take the following actions to maintain this indicator, and so the quality of its services, by fully implementing the Learning from Deaths Framework and continuing to strengthen our mortality monitoring processes including developing the timely review of all deaths , ensuring identification and sharing of learning.

Indicator	Reporting period	Percentage	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	**January 2015 – December 2015**	**33.4**	**27.6**	**0.2** **54.7**
	April 2015 – March 2016	**39.1**	**28.5**	**0.6** **54.6**
	July 2015 – June 2016	**42.8**	**29.2**	**0.6** **54.8**
	October 2015 – September 2016	**48.9**	**29.7**	**0.4** **56.3**
	***January 2016 – December 2016 data to be published by NHS Digital 22nd June 2017**			

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The clinical coding team and palliative care teams have worked together to increase the accuracy of coding of palliative care and are confident that the improved percentage reflect this work

St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by the close collaboration of clinical coding and palliative

care teams to improve the accuracy of coding to fully capture the involvement of palliative care services. Since October 2016 we have received a locally agreed tariff for specialist palliative care.

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The percentage of patients aged: (i) 0 to 15 and (ii) 16 or over re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	**8.1%** **13.1%**	**7.6%** **13.3%**	**6.9%** **9.4%**	**Highest (0-15) 16.1%, Lowest 1.2%** **Highest (16 or over) 15.6% Lowest 1.5%** **Our peers on Dr Foster**

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Monitoring emergency re-admission rates help the Trust to prevent or reduce unplanned re-admission into the hospital. An emergency re-admission occurs when a patient has an unplanned re-admission to hospital with 30 days of a previous discharge.

St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by committing to reducing re-admission for all patients irrespective of whether that care is planned or unplanned. We will work to improve our current overall re-admission rate of 12.1% by ensuring that all patients are discharged when it is safe to do so and that there is a coordinated approach with our partners and local authorities to ensure that the right support is in place for them.

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The Trust's responsiveness to the personal needs of its patients during the reporting period: Friends and Family Test scores (percentage of people who said they were "Extremely likely" or "Likely" to recommend our services to friends and	**94% (n=30031)**	**92% (n=29738)**	**93% (March 2017)**	**Highest: 100%** **Lowest: 76% (Feb Inpatient 2017)**

family members)				

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

St George's University Hospitals NHS Foundation Trust intends to take the following actions to maintain and improve this percentage, and so the quality of its services, by continuous and on-going engagement with patients, family, friends and carers.

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	**73%**	**75%**	**80%**	**Highest: 100% Lowest: 44%**

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The majority of staff are proud of the care that they provide and would recommend the Trust as a provider of care to their family or friends.

St George's University Hospitals NHS Foundation Trust intends to improve this percentage, and so the quality of its services, by focusing on staff engagement and quality improvement, listening to staff and addressing their concerns around bullying and harassment and equality and diversity (amongst other issues).

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	**96%**	**96.7%**	**2015/16: 95.8%** ***2016/17: 95.6%**	**2015/16: 100% (highest quarterly rate) 61.5% (lowest quarterly**

			***national data is for Q1-Q3 as Q4 data is not yet available via NHS England – to be published in June 2017**	**rate)** ***2016/17: 100% (highest quarterly rate) 72.1% (lowest quarterly rate)**

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by maintaining our high risk assessment rate (this is currently higher than the national average).

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The rate per 100,000 bed days of cases of *C.difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period.	**11.77**	**9.45**	**13.62 (median)**	**64.1** **0.0**

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The rate for St George's is lower than the majority of other acute London Teaching hospitals and was the 7th lowest of all 29 acute teaching hospital trusts in England.

St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by implementation of the following processes; improved recognition of patients at risk of infection by alerting Infection Prevention and Control Team when patients with past history are admitted, improving diagnostic screening of patients at risk and planning that all wards are decanted and deep cleaned on a regular basis.

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts

The number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	***12,087** **27** of these incidents were reported to have resulted in severe harm or death (0.2%)	**11,216** **38** of these incidents were reported to have resulted in severe harm or death (0.3%)	National data for the last 6 months of 2016/17 will not be published by the NRLS until September 2017 (and so cannot be provided at this stage).	National data for the last 6 months of 2016/17 will not be published by the NRLS until September 2017 (and so cannot be provided at this stage).

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this number and rate, and so the quality of its services, by introducing a number of learning initiatives and continuing to work towards enhancing existing mechanisms throughout 2016/17. These include: risk management input into training programmes, increased frequency of root cause analysis (RCA) training, increased involvement from medical staff in following up incidents, a monthly governance newsletter and the introduction of quarterly analysis report.

*The Trust is in the middle 50% of reporters to the National Reporting and Learning System (NRLS). Data is correct as at 30/05/2017.

Independent Practitioner's Limited Assurance Report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation Trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation Trusts 2016/17' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers. We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation Trust annual reporting manual 2016/17 and supporting guidance;
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation Trusts 2016/17'; and
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation Trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2016 to 31 May 2017

- Papers relating to quality reported to the Board over the period 1 April 2016 to 31 May 2017
- Feedback from Commissioners dated 17 May 2017
- Feedback from Governors dated 24 May 2017
- Feedback from local Healthwatch organisations dated 15 May 2017
- Feedback from Overview and Scrutiny Committee dated 15 May 2017
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2016
- The national patient survey dated 8 June 2016
- The local patient survey dated 2016
- The national staff survey dated 2016
- The local staff survey dated 2016
- The Care Quality Commission inspection report dated 1 November 2016
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 25 May 2017

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and St George's University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;

- Comparing the content requirements of the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by St George's University Hospitals NHS Foundation Trust.

Our audit work on the financial statements of St George's University Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as St George's University Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to St George's University Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of St George's University Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than St George's University Hospitals NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- The Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation Trust annual reporting manual 2016/17 and supporting guidance;
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation Trusts 2016/17'; and

- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance.
-

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
London

Date: 31 May 2017